

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		c. LENGTH OF STAY IN 1b 7 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY HAMPSHIRE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROMNEY		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First THOMAS	Middle F.	Last BARTLETT	4. DATE OF DEATH	Month JULY	Day 17	Year 1956		
S. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 25, 1875	9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retire Cook - New Century Hotel		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Vince Bartlett				14. MOTHER'S MAIDEN NAME Kathleen Gales					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 236-12-1720		17. INFORMANT Memorial Hospital		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic nephritis with uremia - DUE TO 592X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis - DUE TO Benign hypertrophy prostate (c) 592X								INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 7-17-56		(County) 7-17-56	(State) 7-17-56
21. I certify that I attended the deceased from 7-10-56 to 7-17-56 that I last saw the deceased alive on 7-16-56 , and that death occurred at 10:05 AM , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) 7-17-56 DATE SIGNED 7-17-56									
ACTUAL SIGNATURE Howard L. Tolson									
PHYSICIAN'S NAME (Type) HOWARD L. TOLSON									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial July 19, 1956		22b. DATE THEREOF July 19, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Colored Cem.		22d. LOCATION (City, town, or county) Romney		(State) W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Keith Shaffer		ADDRESS Romney, W. Va.		24a. REC'D BY REGISTRAR July 19, 1956		24b. REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.			

JUL 20 1956

RECEIVE

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06709

5728

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1/23/56							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) John L. Becker		First John	Middle L.	Last Becker	4. DATE OF DEATH July 21, 1956	Month July	Day 21	Year 1956	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 9/27/1879	9. AGE (in years lost birthday) yrs. 76	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired R. R. worker-Western Md.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Louis Becker		14. MOTHER'S MAIDEN NAME Elizabeth Michaels							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT Allegany County Infirmary Records		Address P.O. Box 599			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Chronic myocardial degeneration		INTERVAL BETWEEN ONSET AND DEATH ? ?					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 422.2		Cerebral arteriosclerosis.		? ?					
(b) DUE TO		Pulmonary hypertension		? ?					
(c)		Arthritis deformans							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Injury occurred at home due to heart condition.							
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cumberland	(County) Carroll	(State) Md.		
21. I certify that I attended the deceased from 1/23/56 , 19, to 7/21/56 , 19, that I last saw the deceased alive on 7/21/56 , 19, and that death occurred at 4:48 P.M. from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) 49 Greene St., Cumberland, Md.									
DATE SIGNED 7/23/56									
ACTUAL SIGNATURE James E. McLean									
PHYSICIAN'S NAME (Type) Dr. James E. McLean		22d. LOCATION (City, town, or county) Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/23/56	22c. NAME OF CEMETERY OR CREMATORIAL St. Peter & Paul		(State) Md.				
23. FUNERAL DIRECTOR'S SIGNATURE James Stein Inc.		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR July 24, 1956		24b. REGISTRAR'S SIGNATURE W. F. Tracy, M.D.				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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JUL 25 1956

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06710

CERTIFICATE OF DEATH

5782

Reg. Dist. No. 9

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY TOWN	Allegany Frostburg	MARYLAND LENGTH OF STAY (in this place)	STATE TOWN STREET ADDRESS
HOSPITAL OR INSTITUTION OR STREET ADDRESS		COUNTY Allegany CITY (If outside corporate limits, write RURAL OR and give nearest town) Nikep	
Miners Hospital		(If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) Emma		(Month) 7/24/1956 (Day) (Year) 19	
(Middle)	(Last)		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Female	White	Widowed	4/2/1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
House work Own Home		Lonaconing	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Arch Brown		Emma Beeman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
No		None	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION (Daughter)	
		Mrs. Lester Watkinson	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
550. IMMEDIATE CAUSE (A) Uremia ANTECEDENT CAUSE(S) DUE TO acute Gangrenous Appendicitis INTERVAL BETWEEN DISEASES OR CONDITIONS, IF ANY, (B) Diabetes Hyper tension ONSET AND DEATH GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO 7 Days (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
July 21 1956		acute Gangrenous Appendicitis	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
M.		at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from July 20, 1956 , to July 28, 1956 , that I last saw the deceased alive on July 23, 1956 , and that death occurred at 9:22 A.M. from the causes and on the date stated above. SIGNATURE George Eichhorn, MD M.D. ADDRESS (Street, city, town, state) Frostburg, MD DATE SIGNED July 27 1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7/28/1956	
		NAME OF CEMETERY OR CREMATORIAL Laurel Hill Cemetery	
		LOCATION (City, town, or county) Moscow, MD.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE	
DATE 7-28-56		George Eichhorn, Lonaconing, MD.	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	

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July 31 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6729

CERTIFICATE OF DEATH

06711

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it may be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland (Inside City Limits)		c. LENGTH OF STAY IN 1b 10 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland (Inside City Limits)		d. STREET ADDRESS Willowbrook Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Willowbrook Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Ida		First Belle	Middle Bible	Last Bible	4. DATE OF DEATH July 13	Month July	Day 13	Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH May 17, 1871	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Morral				14. MOTHER'S MAIDEN NAME Rebecca Dean				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. none		17. INFORMANT Melvin Bible Cumberland, Md.		
Address								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis INTERVAL BETWEEN ONSET AND DEATH 5 years								
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Atherosclerotic arteriosclerosis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 7-16-56								
ACTUAL SIGNATURE J. T. Johnson		M.D. James T. Johnson, M.D.						
PHYSICIAN'S NAME (Type) J. T. Johnson, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/16/56		22c. NAME OF CEMETERY OR CREMATORIUM Bible Cemetery		22d. LOCATION (City, town, or county) Flintstone, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. Lee Silcox Cumberland, Md.								
24a. REC'D BY REGISTRAR July 16, 1956					24b. REGISTRAR'S SIGNATURE E.W. Frank, M.D.			

RECEIVED
FEB 18 1956

BUREAU X

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06712

Reg. Dist. No.

DR. R. J. WMS. 6730

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NIKEP		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First MARGARET	Middle	Last	4. DATE OF DEATH	Month JULY	Day 14	Year 1873	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 5, 1873	9. AGE (In years lost birthday) 83 yrs.	IF UNDER 1 YEAR Months 83	IF UNDER 24 HRS. Days 0	Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME CHARLES WARNICK		14. MOTHER'S MAIDEN NAME MARTHA FAZENBAKER						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT MEMORIAL HOSPITAL-MEMORIAL-MEMORIAL & WARWICK AVE	Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 24 hrs								
DUE TO Hypertension not known								
DUE TO —								
(c) —								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year — 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) —	(County) —	(State) —		
21. I certify that I attended the deceased from 7/13/56 , 19, to 7/14/56 19, that I last saw the deceased alive on 7/14/56 , 19, and that death occurred at 5:58 P.M., from the causes and on the date stated above.								
ACTUAL SIGNATURE B. J. Williams, M.D.								
ADDRESS (Street, city or town, state) —								
DATE SIGNED 7/14/56								
PHYSICIAN'S NAME (Type)		B. J. WILLIAMS, M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-17-56		22c. NAME OF CEMETERY OR CREMATORIUM Laurel Hill Cemetery		22d. LOCATION (City, town, or county) Moscow, Maryland.		
(State) —								
23. FUNERAL DIRECTOR'S SIGNATURE Elmerach. St. Balal Nestor part. Md.		ADDRESS —		24a. REC'D BY REGISTRAR July 16, 1956		24b. REGISTRAR'S SIGNATURE W. Frank, M.D.		
DATE —								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06713

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL
and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

14 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

W.Va.

b. COUNTY Mineral

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Ridgely

3. NAME OF
DECEASED
(Type or print)

First
Robert

Middle
Monroe

Last
Bower

4. DATE
OF
DEATH

July

Day
3
Year
1956

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Feb. 24-1936

9. AGE (In years
last birthday)

20
yrs.

10. IF UNDER 1 YEAR

Months
Days

11. IF UNDER 24 HRS.

Hours
Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Apprentice, Millwright, Hinkle Bros.

10b. KIND OF BUSINESS OR INDUSTRY

Hinkle Bros.

11. BIRTHPLACE (State or foreign country)

Morgantown, W.Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harley Bower

14. MOTHER'S MAIDEN NAME

Donna Still

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

235-52-2951

17. INFORMANT

Memorial Hospital records.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Toxemia

INTERVAL BETWEEN
ONSET AND DEATH

916.3

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

1st. 2nd. & 3rd. degree burns of body

14 days

DUE TO

(c) Gas leak, explosion & flash fire.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Gas leak, explosion & flash fire at the new Pittsburg

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 7.30 p.m. 6-10

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City/town) North Branch (County) (State)

Pitt. P& G. Plant Cumberland Allegany Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

H. V. Deming M.D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

July 3-1956

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

July 6, 1956

22c. NAME OF CEMETERY OR CREMATORI

Morgantown Cemetery

22d. LOCATION (City, town, or county)

Morgantown, West Virginia.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Fred L. Jenkins Funeral Home, Morgantown,

ADDRESS

W.Va.

24a. REC'D BY REGISTRAR

Date

July 6, 1956

24b. REGISTRAR'S SIGNATURE

Date

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files.
Forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JUL 9 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06714

Reg. Dist. No.

4

1. PLACE OF DEATH
o. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

1 day

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

o. STATE

Md.

b. COUNTY

Allegany

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

First
John

Middle
Joseph

Last
Brant

4. DATE
OF
DEATH

July

27

19 56

S. SEX

male

6. COLOR OR RACE
white

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

Nov. 14-1899

9. AGE (In years
last birthday)
56 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

none

10b. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Cumberland,

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Norman Brant

14. MOTHER'S MAIDEN NAME

Veletta Pitzer

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Memorial Hospital records

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Chronic lymphatic leukemia

INTERVAL BETWEEN
ONSET AND DEATH

4 yrs

204.0
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

Retroperitoneal hemorrhage

about

3 days

DUE TO

Enlarged spleen

(c)

Etechia of lungs.

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

H.V. Deming M.D.

DATE SIGNED

EXAMINER'S
NAME (Type) H.V. Deming M.D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER July 27-1956

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

Zion Memorial Cemetery

22d. LOCATION (City, town, or county)

(State)

Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REG'D BY REGISTRAR

July 29, 1956

24b. REGISTRAR'S SIGNATURE

W.R. Frantz, M.D.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

V.S. A15ME(S)
SM 9/55

BUREAU V. S.

JUL 31 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06715

Reg. Dist. No. 8

1. PLACE OF DEATH
o. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL
and give nearest town)

Nikep

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

In garage at home.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

o. STATE

Md.

b. COUNTY

Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Nikep

d. STREET ADDRESS

Box 181 Barton, Md.

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First
Bertha

Middle

Last
R. Broadwater

4. DATE
OF
DEATH

Month
July

Day
27
Year
1956

5. SEX

Female

6. COLOR OR RACE

white

7. MARRIED

NEVER MARRIED
WIDOWED
DIVORCED

8. DATE OF BIRTH

March 19-1892

9. AGE (In years
last birthday)

64
yrs.

10. IF UNDER 1 YEAR

Months
Days

11. IF UNDER 24 HRS.

Hours
Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

(rural) Garrett, Co.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Green

14. MOTHER'S MAIDEN NAME

Anna Winebrenner

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

none

17. INFORMANT

(son) Forest Broadwater, Nikep, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Asphyxia due to strangulation by Hanging

INTERVAL BETWEEN
ONSET AND DEATH
about

5 min.

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause first.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Hung herself in garage by strips of muslin.

20c. TIME OF INJURY Month, Day, Year
Hour

3.30 p.m. July 27 1956

20d. INJURY OCCURRED

While at work Not while at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

Home, in garage

20f. (City or town)

Nikep, Allegany

(County)

(State)

Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

H.V. Deming M.D.

DATE SIGNED

EXAMINER'S
NAME (Type)

H.V. Deming M.D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

July 27-1956

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

7-30-56

22c. NAME OF CEMETERY OR CREMATORIUM

Laurel Hill

22d. LOCATION (City, town, or county)

Moscow,

(State)

Md.

23. FUNERAL DIRECTOR'S SIGNATURE

24a. REC'D BY REGISTRAR

DATE

7/28/56

24b. REGISTRAR'S SIGNATURE

Janeville in Board

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

V.S. A15ME(S)
5M 9/55

WILDCAT EXAMINER-CERTIFICATE OF MAILING - THE HOME OF
THE WILDCAT EXAMINER

BUREAU Y.

AUG 3 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06716

CERTIFICATE OF DEATH

Reg. Dist. No.

6793

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rt. 1, Frostburg

c. LENGTH OF STAY IN 1b

life

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Maryland

b. COUNTY Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rt. 1, Frostburg

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

female

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

B. DATE OF BIRTH

5-15-1895

9. AGE (In years
last birthday)

61 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

housework

10b. KIND OF BUSINESS OR INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Wm. H. Barnes

14. MOTHER'S MAIDEN NAME

Ellen J. Loar

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Mrs. Albert Ritchie, Rt. 1, Frostburg, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

CARCINOMA of the TRANSVERSE COLON 2 yrs

MEDICAL CERTIFICATION

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. p. m. 19
p. m.20d. INJURY OCCURRED
White Nat while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from AUG. 1955 to JULY 11, 1956, that I last saw the deceased alive on JULY 9, 1956, and that death occurred at 4A M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

John C Deacon M.D.

Frostburg, Md. 7/11/56

PHYSICIAN'S
NAME (Type)

John C. Deacon

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

7-13-1956

22c. NAME OF CEMETERY OR CREMATORI

F' bg. Memorial Park

22d. LOCATION (City, town, or county)

Frostburg, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

J. R. Durst, Frostburg, Md.

ADDRESS

24a. REC'D BY REGISTRAR

DATE 7-13-56

24b. REGISTRAR'S SIGNATURE

Daisy N. Res

06717

CERTIFICATE OF DEATH
6733

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After the death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN Cumberland	Allegany MARYLAND LENGTH OF STAY (In this place) 2/25/55	STATE Maryland COUNTY Allegany	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary		STREET ADDRESS 315 Maryland Avenue	(If rural give location)
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
(First) Oscar (Middle) Earl (Last) Burkett		OF DEATH July 12, 1956	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH 3/30/1894
9. AGE last birthday 62 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipefitter - Celanordajene Corp.		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) Ellerslie, Maryland	
13. FATHER'S NAME William Harvey Burkett		14. MOTHER'S MAIDEN NAME Deborah Elliott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 214-07-0246	
17. INFORMANT & ADDRESS Allegany County Infirmary Records		18. MEDICAL CERTIFICATION	
<p>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p>331X IMMEDIATE CAUSE (A) Cerebral Hemorrhage</p> <p>ANTECEDENT CAUSE(S) DUE TO</p> <p>DISEASES OR CONDITIONS, IF ANY, (B) Cerebral Arterio sclerosis</p> <p>GIVING RISE TO THE ABOVE CAUSE STATEMENT UNDERLYING CAUSE LAST. DUE TO</p> <p>(C) Chronic myocarditis</p> <p>Chronic nephritis</p>			
INTERVAL BETWEEN ONSET AND DEATH 1/2 yrs.			
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</p>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, NOTIFY MEDICAL EXAMINER)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
<p>22. I hereby certify that I attended the deceased from..... 2/25/1955, to..... 7/12/1956, that I last saw the deceased alive on..... 7/12/1956, and that death occurred at..... 5:30 P.M., from the causes and on the date stated above.</p> <p>SIGNATURE Dr. James E. McLean M.D.</p> <p>ADDRESS (Street, city, town, state) DATE SIGNED 7/13/56</p>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7/15/56 NAME OF CEMETERY OR CREMATORIUM Greenmount Cemetery	
24. REC'D BY REGISTRAR July 15, 1956		LOCATION (City, town, or county) Cumberland, Maryland (State)	
REGISTRAR'S SIGNATURE Writer R. Frank, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. Wayne George Cumberland, Md.	

Period	Number of Buses	Number of Passenger Cars	Number of Trucks	Number of Motorcycles	Number of Cycles	Number of Vans	Number of Buses	Number of Passenger Cars	Number of Trucks	Number of Motorcycles	Number of Cycles	Number of Vans
1970-71	10	100	10	10	10	10	10	100	10	10	10	10
1971-72	15	150	15	15	15	15	15	150	15	15	15	15
1972-73	20	200	20	20	20	20	20	200	20	20	20	20
1973-74	25	250	25	25	25	25	25	250	25	25	25	25
1974-75	30	300	30	30	30	30	30	300	30	30	30	30
1975-76	35	350	35	35	35	35	35	350	35	35	35	35
1976-77	40	400	40	40	40	40	40	400	40	40	40	40
1977-78	45	450	45	45	45	45	45	450	45	45	45	45
1978-79	50	500	50	50	50	50	50	500	50	50	50	50
1979-80	55	550	55	55	55	55	55	550	55	55	55	55
1980-81	60	600	60	60	60	60	60	600	60	60	60	60
1981-82	65	650	65	65	65	65	65	650	65	65	65	65
1982-83	70	700	70	70	70	70	70	700	70	70	70	70
1983-84	75	750	75	75	75	75	75	750	75	75	75	75
1984-85	80	800	80	80	80	80	80	800	80	80	80	80
1985-86	85	850	85	85	85	85	85	850	85	85	85	85
1986-87	90	900	90	90	90	90	90	900	90	90	90	90
1987-88	95	950	95	95	95	95	95	950	95	95	95	95
1988-89	100	1000	100	100	100	100	100	1000	100	100	100	100
1989-90	105	1050	105	105	105	105	105	1050	105	105	105	105
1990-91	110	1100	110	110	110	110	110	1100	110	110	110	110
1991-92	115	1150	115	115	115	115	115	1150	115	115	115	115
1992-93	120	1200	120	120	120	120	120	1200	120	120	120	120
1993-94	125	1250	125	125	125	125	125	1250	125	125	125	125
1994-95	130	1300	130	130	130	130	130	1300	130	130	130	130
1995-96	135	1350	135	135	135	135	135	1350	135	135	135	135
1996-97	140	1400	140	140	140	140	140	1400	140	140	140	140
1997-98	145	1450	145	145	145	145	145	1450	145	145	145	145
1998-99	150	1500	150	150	150	150	150	1500	150	150	150	150
1999-2000	155	1550	155	155	155	155	155	1550	155	155	155	155
2000-2001	160	1600	160	160	160	160	160	1600	160	160	160	160
2001-2002	165	1650	165	165	165	165	165	1650	165	165	165	165
2002-2003	170	1700	170	170	170	170	170	1700	170	170	170	170
2003-2004	175	1750	175	175	175	175	175	1750	175	175	175	175
2004-2005	180	1800	180	180	180	180	180	1800	180	180	180	180
2005-2006	185	1850	185	185	185	185	185	1850	185	185	185	185
2006-2007	190	1900	190	190	190	190	190	1900	190	190	190	190
2007-2008	195	1950	195	195	195	195	195	1950	195	195	195	195
2008-2009	200	2000	200	200	200	200	200	2000	200	200	200	200
2009-2010	205	2050	205	205	205	205	205	2050	205	205	205	205
2010-2011	210	2100	210	210	210	210	210	2100	210	210	210	210
2011-2012	215	2150	215	215	215	215	215	2150	215	215	215	215
2012-2013	220	2200	220	220	220	220	220	2200	220	220	220	220
2013-2014	225	2250	225	225	225	225	225	2250	225	225	225	225
2014-2015	230	2300	230	230	230	230	230	2300	230	230	230	230
2015-2016	235	2350	235	235	235	235	235	2350	235	235	235	235
2016-2017	240	2400	240	240	240	240	240	2400	240	240	240	240
2017-2018	245	2450	245	245	245	245	245	2450	245	245	245	245
2018-2019	250	2500	250	250	250	250	250	2500	250	250	250	250
2019-2020	255	2550	255	255	255	255	255	2550	255	255	255	255
2020-2021	260	2600	260	260	260	260	260	2600	260	260	260	260
2021-2022	265	2650	265	265	265	265	265	2650	265	265	265	265
2022-2023	270	2700	270	270	270	270	270	2700	270	270	270	270
2023-2024	275	2750	275	275	275	275	275	2750	275	275	275	275
2024-2025	280	2800	280	280	280	280	280	2800	280	280	280	280
2025-2026	285	2850	285	285	285	285	285	2850	285	285	285	285
2026-2027	290	2900	290	290	290	290	290	2900	290	290	290	290
2027-2028	295	2950	295	295	295	295	295	2950	295	295	295	295
2028-2029	300	3000	300	300	300	300	300	3000	300	300	300	300
2029-2030	305	3050	305	305	305	305	305	3050	305	305	305	305
2030-2031	310	3100	310	310	310	310	310	3100	310	310	310	310
2031-2032	315	3150	315	315	315	315	315	3150	315	315	315	315
2032-2033	320	3200	320	320	320	320	320	3200	320	320	320	320
2033-2034	325	3250	325	325	325	325	325	3250	325	325	325	325
2034-2035	330	3300	330	330	330	330	330	3300	330	330	330	330
2035-2036	335	3350	335	335	335	335	335	3350	335	335	335	335
2036-2037	340	3400	340	340	340	340	340	3400	340	340	340	340
2037-2038	345	3450	345	345	345	345	345	3450	345	345	345	345
2038-2039	350	3500	350	350	350	350	350	3500	350	350	350	350
2039-2040	355	3550	355	355	355	355	355	3550	355	355	355	355
2040-2041	360	3600	360	360	360	360	360	3600	360	360	360	360
2041-2042	365	3650	365	365	365	365	365	3650	365	365	365	365
2042-2043	370	3700	370	370	370	370	370	3700	370	370	370	370
2043-2044	375	3750	375	375	375	375	375	3750	375	375	375	375
2044-2045	380	3800	380	380	380	380	380	3800	380	380	380	380
2045-2046	385	3850	385	385	385	385	385	3850	385	385	385	385
2046-2047	390	3900	390	390	390	390	390	3900	390	390	390	390
2047-2048	395	3950	395	395	395	395	395	3950	395	395	395	395
2048-2049	400	4000	400	400	400	400	400	4000	400	400	400	400
2049-2050	405	4050	405	405	405	405	405	4050	405	405	405	405
2050-2051	410	4100	410	410	410	410	410	4100	410	410	410	410
2051-2052	415	4150	415	415	415	415	415	4150	415	415	415	415
2052-2053	420	4200	420	420	420	420	420	4200	420	420	420	420
2053-2054	425	4250	425	425	425	425	425	4250	425	425	425	425
2054-2055	430	4300	430	430	430	430	430	4300	430	430	430	430
2055-2056	435	4350	435	435	435	435	435	4350	435	435	435	435
2056-2057	440	4400	440	440	440	440	440	4400	440	440	440	440
2057-2058	445	4450	445	445	445	445	445	4450	445	445	445	445
2058-2059	450	4500	450	450	450	450	450	4500	450	450	450	450
2059-2060	455	4550	455	455	455	455	455	4550	455	455	455	455
2060-2061	460	4600	460	460	460	460	460	4600	460	460	460	460
2061-2062	465	4650	465	465	465	465	465	4650	465	465	465	465
2062-2063	470	4700	470	470	470	470	470	4700	470	470	470	470
2063-2064	475	4750	475	475	475	475	475	4750	475	475	475	475
2064-2065	480	4800	480	480	480	480	480	4800	480	480	480	480
2065-2066	485	4850	485	485	485	485	485	4850	485	485	485	485
2066-2067	490	4900	490	490	490	490	490	4900	490	490	490	490
2067-2068	495	4950	495	495	495	495	495	4950	495	495	495	495
2068-2069	500	5000	500	500	500	500	500	5000	500	500	500	500
2069-2070	505	5050	505	505	505	505	505	5050	505	505	505	505
2070-2071	510	5100	510	510	510	510	510	5100	510	510	510	510
2071-2072	515	5150	515	515	515	515	515	5150	515	515	515	515
2072-2073	520	5200	520	520	520	520	520	5200	520	520	520	520
2073-2074	525	5250	525	525	525	525	525	5250	525	525	525	525
2074-2075	530	5300	530	530	530	530						

READY TO USE

1956 JUL 18 28 125 S

REFEEI VEDO
JUL 18 1955

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-L55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**6734 CERTIFICATE OF DEATH**

06718

Reg. Dist. No. 4

1. PLACE OF DEATH

COUNTY	Allegany	MARYLAND
CITY (If outside corporate limits, write RURAL or end give nearest town)	LENGTH OF STAY (in this place)	
TOWN	Cumberland 11/23/53	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Allegany County Infirmary	

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE	Maryland	COUNTY	Allegany
CITY (If outside corporate limits, write RURAL and give nearest town)	02		
TOWN	Cumberland		
STREET ADDRESS	(If rural give location) 232 N. Centre Street		

**3. NAME OF DECEASED
(Type or Print)**

(First)	(Middle)	(Last)
Mabel	L.	Byrd

4. DATE OF DEATH	(Month)	(Day)	(Year)
July 10,			19 56

S. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday
Female	White	Widow	6/8/1894	62 yrs.

IF UNDER 1 YEAR	IF UNDER 24 HRS.
Months	Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Upper Track, Pennsylvania (Pendleton County)	U. S. A.

13. FATHER'S NAME

Solon K. Lantz

14. MOTHER'S MAIDEN NAME

Mary Alice Teter

15. WAS DECEASED EVER IN U. S. ARMED FORCES?	16. SOCIAL SECURITY NO.
NO (Yes, no, or unk.)	220-10-9367

17. INFORMANT & ADDRESS

Allegany County Infirmary Records

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 IMMEDIATE CAUSE (A)	Chronic Myocardiitis	INTERVAL BETWEEN ONSET AND DEATH ?
ANTECEDENT CAUSE(S) DUE TO	General arteriosclerosis	?
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B)	Secondary anemia	?
STATING UNDERLYING CAUSE LAST. DUE TO (C)	Arthritis deformans	?

18. MEDICAL CERTIFICATION**II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.****19a. DATE OF OPERATION****19b. MAJOR FINDINGS OF OPERATION****20. AUTOPSY?**YES NO

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town)
--	--	---

(County) (State)

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED
-----------------------------	-------	--------	--------	----------------------

21f. HOW DID INJURY OCCUR?

M. While at work Not while at work

22. I hereby certify that I attended the deceased from 11/23/1953 to 7/10/1956, that I last saw the deceased

alive on 7/10/1956, and that death occurred at 2:45 P.M. from the causes and on the date stated above.

SIGNATURE

Dr. James E. McLean

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county)

(State)

Burial

July 13, 1956

Cedar Hill Cem

Franklin, West Virginia

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

July 13, 1956

Winter F. Frank, M.D.

John J. Hafer, Cumberland, Md.

BUREAU V.

JUL 16 1956

JUL 16 1966
REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06719

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6 HRS 45 MINS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First BERTHA	Middle L.	Last CARNEY
4. DATE OF DEATH	7	Month	Day Year 5 19 56
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 17 1886
9. AGE (In years lost birthday) yrs. 89	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Came Home</i>	10b. KIND OF BUSINESS OR INDUSTRY House Wife	11. BIRTHPLACE (State or foreign country) W.V.A.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME L. SAMPLE JOHNSON	14. MOTHER'S MAIDEN NAME MARY SWEARENGIN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT MEMORIAL HOSPITAL	Address MEMORIAL AVENUE
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO Hypertensive Cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH 10 hours.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1956 to 7-5-1956 that I last saw the deceased alive on 7-5-1956 and that death occurred at 11:25 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wm. J. Williams</i>	ADDRESS (Street, city or town, State) Cumberland Md		
PHYSICIAN'S NAME (Type) DR. W.F. WMS.	DATE SIGNED 7-6-56		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 7 1956	22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland Md
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Right</i>	ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DATE July 6, 1956	24b. REGISTRAR'S SIGNATURE <i>W.L. Gandy, M.D.</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED JUL 9 1956 **BUREAU Y. S.**

1956 9 July

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06720

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

6736 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

COUNTY

Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL
OR end give nearest town)
TOWN

Cumberland

LENGTH OF STAY
(In this place)

12/17/53

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

Maryland

COUNTY

Allegany

CITY (If outside corporate limits, write RURAL and give nearest town)

Cumberland

STREET
ADDRESS

438 Goethe Street

(If rural give location)

3. NAME OF
DECEASED
(Type or Print)

Mary

C.

Claar

4. DATE (Month) (Day) (Year)

July 31,

1956

5. SEX

6. COLOR OR
RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

Widow

8. DATE OF BIRTH

8/15/1866

9. AGE last birthday
yrs.

89

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

Housewife

10b. KIND OF BUSINESS
OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT
COUNTRY?

U. S. A.

13. FATHER'S NAME

Samuel Sellers

14. MOTHER'S MAIDEN NAME

Rebecca Mower

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.)

(If Yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

None

17. INFORMANT & ADDRESS

P. O. Box 599

Allegany County Infirmary Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 IMMEDIATE CAUSE (A)

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO

(C)

Pulmonary Hypostasis

Chronic Myocarditis

General Arteriosclerosis

Chronic Zephritis

INTERVAL BETWEEN
ONSET AND DEATH

36 hrs

?

?

?

?

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
M. While at work Not while at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/17/53, 19....., to 7/31/56, 19....., that I last saw the deceased
alive on 7/31/56, 19..... and that death occurred at 2:30 P.M. from the causes and on the date stated above.

SIGNATURE

Dr. James E. McLean

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

Burial

DATE THEREOF

8/3/56

NAME OF CEMETERY OR CREMATORIAL

Rose Hill Cemetery

LOCATION (City, town, or county)

(State)

Cumberland, Maryland

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

Aug. 2, 1956 Walter F. Frank, M.D.

25. FUNERAL DIRECTOR'S SIGNATURE

John J. Hafer, Cumberland, Maryland

ADDRESS

10. BOSTONIAN-NEW ENGLAND STATE CHARTER

STATE OF MASSACHUSETTS

Charter
dated

1875

for the purpose of

etc.

1898

etc.

etc.</p

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

106721

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		d. STREET ADDRESS 78 Mt Pleasant St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 78 Mt Pleasant Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Annie		First	Middle	Last	4. DATE OF DEATH Month 7	Day 8th	Year 19 56
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 - 21 - 1870	9. AGE (In years lost birthday) yrs. 85	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Hoffman, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Metzner		14. MOTHER'S MAIDEN NAME Elizabeth Ellen Moody					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT James Henry Connelley, Frostburg, Md.		Address 114 Mt. Pleasant St., Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Neoplasm of Colon				INTERVAL BETWEEN QNSET AND DEATH Two months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gangrenous arteriosclerosis, Chronic Myocarditis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Self-inflicted					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Connelley's home		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-27-56 to 7-5-56 , that I last saw the deceased alive on 7-5-56 , and that death occurred at 3 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE J. T. Johnson Jr. M.D.						ADDRESS (Street, city or town, state) Connelley's home	
PHYSICIAN'S NAME (Type) James T. Johnson Jr. M.D.						DATE SIGNED 7-10-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-11-56		22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul H. Montsant		ADDRESS HAFER FUNERAL HOME 3 E. Main, Frostburg, Md.		24a. REC'D BY REGISTRAR D. Dailey A. Reg		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE GOVERNMENT OF BALTIMORE, MD

CERTIFICATE OF DEATH

BUREAU V. S.

JUL 16 1956

REGD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06722

Reg. Dist. No.

4

6737

1. PLACE OF DEATH
o. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN lb

14 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

o. STATE Md.

b. COUNTY Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

d. STREET ADDRESS

946 Gay St.

e. IS RESIDENCE
ON A FARM?
YES NO

3. NAME OF
DECEASED
(Type or print)

First
Sherman

Middle
Warfield

Last
Crabtree

4. DATE
OF
DEATH

July

19 19 56

5. SEX

Male

6. COLOR OR RACE

white

7. MARRIED

NEVER MARRIED
 WIDOWED
 DIVORCED

8. DATE OF BIRTH

June 24-1898

9. AGE (In years
last birthday)

58

yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Trackman

10b. KIND OF BUSINESS OR INDUSTRY

B& O.R.Ry.

11. BIRTHPLACE (State or foreign country)

Old Town, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Michael Crabtree

14. MOTHER'S MAIDEN NAME

Edna J. Twigg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

214-05-9630

17. INFORMANT

Memorial Hospital Records.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Pulmonary embolism(massive)

about

INTERVAL BETWEEN
ONSET AND DEATH

6 Hrs.

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause lost.

(b) Post-operative cystolithectomy

10 days

DUE TO
(c)

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m.
p. m. 19

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

H. V. Denning M.D.

DATE SIGNED

EXAMINER'S
NAME (Type)

H. V. Denning M.D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

July 19-1956

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

7/21/56

22c. NAME OF CEMETERY OR CREMATORIUM

Bethel Methodist Cam

22d. LOCATION (City, town, or county)

Bedford

(State)

County, Pennsylvania

23. FUNERAL DIRECTOR'S SIGNATURE

John J. Hafer, Cumberland, Maryland

ADDRESS

24a. REC'D BY REGISTRAR

July 21, 1956

24b. REGISTRAR'S SIGNATURE

L. H. Frantz, M.D.

Within corporate limits
If any day is necessary, please enter
and give nearest town.
Page 4 should be
retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, or removal.

VS. A15ME(5)
5M 9/55

DEPARTMENT OF HEALTH—TERRITORY OF GUAM—TOMORROW IS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU Y. S.

JUL 24 1956

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06723

6738

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY GRANT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 16 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PETERSBURG		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First SARAH	Middle	Last DANZENBAKER	4. DATE OF DEATH	Month JULY	Day 21	Year 19 56
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 29, 1890	9. AGE (In years last birthday) yrs. 66	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0	12. IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DOUGLAS SOMMERVILLE		14. MOTHER'S MAIDEN NAME MARGARET WALKER		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Terminal Andraic Failure DUE TO 443x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 2. Hypertension Cardiovacular disease INTERVAL BETWEEN ONSET AND DEATH 1 month 2 years.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Petersburg, West Virginia		(County) Petersburg	(State) West Virginia
21. I certify that I attended the deceased from 5 July , 1956, to 21 July , 1956, that I last saw the deceased alive on 21 July , 1956, and that death occurred at 7:40PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>W. Alfred Van Ormer</i>	ADDRESS (Street, city or town, state) Cumberland, Md.						DATE SIGNED 23 July 56
PHYSICIAN'S NAME (Type) W A VAN ORMER, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 24, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Maple Hill Cemetery			22d. LOCATION (City, town, or county) (State) Petersburg, West Virginia.		
23. FUNERAL DIRECTOR'S SIGNATURE Schaeffer Funeral Home, Petersburg, West Virginia		ADDRESS		24a. REC'D BY REGISTRAR July 23, 1956		24b. REGISTRAR'S SIGNATURE W. Frank M. D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please replace carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE JOURNAL OF CLIMATE AND APPLIED CLIMATE SCIENCE

1

SUREAU V. S.

July 24 1956

REGELVÉD

Within this
corporate limits.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

116724

6739 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

COUNTY Allegany

CITY (If outside corporate limits, write RURAL
OR end give nearest town)

TOWN Cumberland

MARYLAND

LENGTH OF STAY
(In this place)

4yr. 2mo. 21da.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland

COUNTY Allegany

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Westernport

STREET
ADDRESS

(If rural give location)

**3. NAME OF
DECEASED**
(Type or Print)

Nettie

Anna

Dawson

**4. DATE
OF
DEATH**

July

24

1956

5. SEX

F.

6. COLOR OR
RACE

W.

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

W.

8. DATE OF BIRTH

Aug. 10, 1870

9. AGE last birthday

85

10. IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

Housewife

10b. KIND OF BUSINESS
OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Clarkburg, West Va.

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME

James O. Ross

14. MOTHER'S MAIDEN NAME

Margaret Guy

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes or unk.) If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

None

17. INFORMANT & ADDRESS

Mrs. Hazel Fleagle Corriganville Md

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A)
ANTECEDENT CAUSE(S) DUE TO
DISEASES OR CONDITIONS, IF ANY, (B)
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO
(C)

18. MEDICAL CERTIFICATION

Chronic Myocarditis.

INTERVAL BETWEEN
ONSET AND DEATH

General arteriosclerosis

?

Chronic nephritis

?

Mild psychosis.

?

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

M. While at work Not while at work 22. I hereby certify that I attended the deceased from May 3, 1952, to July 24, 1956, that I last saw the deceased
alive on July 23, 1956, and that death occurred at 8:15 A.M. from the causes and on the date stated above.

SIGNATURE

Helen B. Schau

ADDRESS (Street, city, town, state)

DATE SIGNED

7-24-56

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORIAL

LOCATION (City, town, or county)

(State)

Burial

7/27/56

Philips Cem

Westernport Md

Cremation

Registrar's Signature

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Burial

Burton L. Frank, M.D.

E. J. O'Farrell

Westernport, Md

Cremation

July 26, 1956

E. J. O'Farrell

Westernport, Md

23. APPROXIMATE STATE OR TERRITORY TO WHICH THIS INFORMATION APPLIES

CERTIFICATE OF DEATH

DEATH CERTIFICATE

NAME OF DECEASED PERSON

NAME OF FUNERAL DIRECTOR

ADDRESS OF FUNERAL DIRECTOR

ADDRESS OF FUNERAL DIRECTOR

NAME OF DECEASED PERSON

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ADDRESS OF FUNERAL DIRECTOR

BUREAU OF INVESTIGATION

1956 27-720

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06725

6794 CERTIFICATE OF DEATH

Reg. Dist. No. 4

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. Formerly, a certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Allegany Rural Cumberland	MARYLAND LENGTH OF STAY (in this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Rt. 6, Narrows Park		
3. NAME OF DECEASED (Type or Print)	(First) MAUDE	(Middle) ESTELLA	(Last) DEREMER
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify), Widowed	8. DATE OF BIRTH Dec. 26, 1875
9. AGE last birthday 80 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Boartown, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Holland Bane	14. MOTHER'S MAIDEN NAME Rebecca Loar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. None	17. INFORMANT & ADDRESS Marshall Deremer, Cumberland, Md.	
18. MEDICAL CERTIFICATION		19. INTERVAL BETWEEN ONSET AND DEATH 3 days	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		Cerebral hemorrhage Arterosclerotic heart disease	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19e. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. While at work <input type="checkbox"/> et work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov. 19, 1955</u> , to <u>July 16, 1956</u> , that I last saw the deceased alive on <u>17th July, 1956</u> , and that death occurred at <u>11:05 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>William P. James</u> M.D. ADDRESS (Street, city, town, state) <u>441 N. Cedar St. Cumb. Md.</u> DATE SIGNED <u>7-17-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 7/16/56	NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	LOCATION (City, town, or county) Cumberland, Maryland (State)
24. REC'D BY REGISTRAR July 18 1956	REGISTRAR'S SIGNATURE Walter R. Gantz, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland	

BUREAU Y. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06726

9

CERTIFICATE OF DEATH

6784

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	Allegany Frostburg	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Allegany Frostburg, R.F.D. # 1 (If rural give location)		
Miners Hospital		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
Daniel		De Vault	
S. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH May 9th. 1938
9. AGE last birthday 18 yrs.	10. KIND OF BUSINESS OR INDUSTRY School Student		11. BIRTHPLACE (State or foreign country) National, MD
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles De Vault		14. MOTHER'S MAIDEN NAME Ida Mae Beeman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS Charles De Vault, (FATHER)		18. MEDICAL CERTIFICATION Frostburg, MD.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 4010 IMMEDIATE CAUSE (A) Congestive Heart failure		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Cplastic anemia		5 days	
DUE TO (C) Rheumatic fever		4 mos.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) Lenaconing, MD.		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 28, 1956 , to July 23, 1956 , that I last saw the deceased alive on July 23, 1956 , and that death occurred at 7 P.M. from the causes and on the date stated above.			
SIGNATURE Teslin R. Miller			
ADDRESS (Street, city, town, state) Lenaconing, MD.			
DATE SIGNED July 25, 1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7/26/1956	
NAME OF CEMETERY OR CREMATORIAL Memorial Park		LOCATION (City, town, or county) Frostburg, MD.	
24. REC'D BY REGISTRAR 7-26-56		REGISTRAR'S SIGNATURE Mrs. Nancy St. Rose	
25. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lenaconing, MD.		ADDRESS	
DATE 7-26-56			

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Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06727

6740

CERTIFICATE OF DEATH

Reg. Dist. No. 4

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 9 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		d. STREET ADDRESS 105 Poplar St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital, Memorial Ave.				e. IS RESIDENCE ON A FARM? / YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mrs.	Middle Laura	Last De Witt	4. DATE OF DEATH July 29	Month July	Day 29	Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28, 1867	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fox Elisa Merrill		14. MOTHER'S MAIDEN NAME Barbara Broadwater					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Memorial Hospital, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Due to Chr Myocarditis							
(c) Due to Semi. l. t. y							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 8 days P.O - 21 July 56 Intestinal Obst. Hydrops Gall Bladder						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 July 4 , 1956, to 29 July 4 , 1956, that I last saw the deceased alive on 29 July 4 , 1956, and that death occurred at 6.10pm , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 30 July 56	
ACTUAL SIGNATURE Fuller B. Whitworth							
PHYSICIAN'S NAME (Type) FULLER B. WHITWORTH							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August 1, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Philos Cemetery		22d. LOCATION (City, town, or county) Westernport, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Boal's Funeral Home, Westernport, Maryland.		ADDRESS		24a. REC'D BY REGISTRAR July 31, 1956		24b. REGISTRAR'S SIGNATURE W.R. Tracy, M.D.	

CERTIFICATE OF DEATH

1710

MURKIN

BUREAU V.

AUG 1 1956

REGEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6741

CERTIFICATE OF DEATH

06728

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 11/8/52	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. STREET ADDRESS 523 Louisiana Avenue	
3. NAME OF DECEASED (Type or print) John		First G.	Middle Douglas
4. DATE OF DEATH July 23, 1956	Month Day Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 6/29/1867
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Coal Mining		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Douglas		14. MOTHER'S MAIDEN NAME Mary Ghrame	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 70	
17. INFORMANT Allegany County Infirmary Records		Address P.O.Box 599	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)			
Pulmonary Hypertension INTERVAL BETWEEN ONSET AND DEATH 24 hrs			
Chronic Myocarditis. ?			
Senile arteriosclerosis ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Prostatitis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/8/52 , 19, to 7/23/56 , 19, that I last saw the deceased alive on 7/18/56 , 19, and that death occurred at 11:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St., Cumberland, Md. DATE SIGNED 7/24/56			
ACTUAL SIGNATURE James E. McLean			
PHYSICIAN'S NAME (Type) Dr. James E. McLean			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/26/56	22c. NAME OF CEMETERY OR CREMATORIAL Oak Hill Cemetery	22d. LOCATION (City, town, or county) Lonaconing (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	24a. REC'D BY REGISTRAR July 26, 1956
			24b. REGISTRAR'S SIGNATURE Walter R. Frank, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A

JUL 27 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AUSC 1-55 10-M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06729

6795 CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN		MARYLAND LENGTH OF STAY (in this place)		STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		COUNTY Allegany STREET ADDRESS (If rural give location)	
Allegany Lonaconing		High Street		Lonaconing		High Street	
3. NAME OF DECEASED (First) Anna (Middle) (Last) Duckworth				4. DATE OF DEATH July 25 1956			
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH June 27.1875	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Frostburg, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Murphy				14. MOTHER'S MAIDEN NAME Harriet Larue			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? NO		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Calvin Duckworth, (SON) Lonaconing, MD.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) Coronary Occlusion ANTECEDENT CAUSE(S) DUE TO _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) _____ STATING UNDERLYING CAUSE LAST (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19e. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County)		(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 25, 1956, to July 25, 1956, that I last saw the deceased alive on July 25, 1956, and that death occurred at 7 A.M. from the causes and on the date stated above.							
SIGNATURE Leslie R. Miles, M.D. ADDRESS (Street, city, town, state) Lonaconing, Md. DATE SIGNED July 25, 1956							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF July 27, 1956		NAME OF CEMETERY OR CREMATORIAL Oak Hill Cemetery Lonaconing, Md.		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR DATE 7/28/56		REGISTRAR'S SIGNATURE Jannette Jo Boal		25. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	

STATE OF NEVADA - DEPARTMENT OF STATE AUDITORS

STATE OF NEVADA

BUREAU V. S.

AG 3 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6742

CERTIFICATE OF DEATH

067-0

Reg. Dist. No. 4

Within corporate limits.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 89 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 48. Browning St		d. STREET ADDRESS 48. Browning St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Joanna	Middle 	Last Dunlap	4. DATE OF DEATH Oct 16 1866	Month July	Day 22	Year 1956
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 16 1866	9. AGE (In years last birthday) yrs. 89	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Home		10b. KIND OF BUSINESS OR INDUSTRY House Wife		11. BIRTHPLACE (State or foreign country) Cumberland Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cheston Johnson		14. MOTHER'S MAIDEN NAME Louise Jackson		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Thomas Ricker, Cumberland, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Uraemia INTERVAL BETWEEN ONSET AND DEATH 6 mts.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Chronic Myocarditis 3 yrs.		(c) DUE TO Arterosclerosis 5 yrs.					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 1951, to July 22 , 1951, that I last saw the deceased alive on July 1 , 1951, and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 236 The Big Canal DATE SIGNED Clayton Burnett M.D. 7/23/51							
ACTUAL SIGNATURE Clayton Burnett		PHYSICIAN'S NAME (Type) Hyndman Cemetery					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 25 1956		22c. NAME OF CEMETERY OR CREMATORIUM Hyndman Cemetery		22d. LOCATION (City, town, or county) Hyndman Pa	
23. FUNERAL DIRECTOR'S SIGNATURE John Eight		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR July 24, 1956 W.R. Frank, M.D.		24b. REGISTRAR'S SIGNATURE	

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

067-1

Reg. Dist. No.

6743

1. PLACE OF DEATH
o. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN lb

4 hrs

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

First
Robert

Middle
Little

Last
Ebert

5. SEX

6. COLOR OR RACE

male

white

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

Child

11. BIRTHPLACE (State or foreign country)

Cumberland, Md.

13. FATHER'S NAME

Robert Little Ebert Sr.

14. MOTHER'S MAIDEN NAME

Elta May Schultz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Memorial Hospital records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

902.0

Shock, head injuries with a depressed skull fracture

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b) fracture, intracranial hemorrhage, cerebral

INTERVAL BETWEEN
ONSET AND DEATH

5 hrs.

DUE TO

(c) injury extensive. Fell from an apple tree.

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)

Climbed apple tree fell about 12 ft. striking on head.

20c. TIME OF INJURY Month, Day, Year
Hour

7-22

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County)
(State)

Back yard, home

Cumberland Allegany Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

H.V.Deming M.D.

DATE SIGNED

EXAMINER'S
NAME (Type)

H.V.Deming H.D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

July 23-1956

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

July 24, 1956

22c. NAME OF CEMETERY OR CREMATORIUM

Hillcrest Burial Park

22d. LOCATION (City, town, or county)

Cumberland, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

John J. Hafer, Cumberland, Maryland.

ADDRESS

Hafer

24a. REC'D BY REGISTRAR

July 24, 1956 W.R. Frantz, M.D.

24b. REGISTRAR'S SIGNATURE

BUREAU V. S.

JUL 25 1956

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

6744

Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Allegany CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Cumberland		MARYLAND LENGTH OF STAY (In this place) 5 wks	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 127 South Mechanic Street		STATE Maryland COUNTY Allegany CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cumberland STREET ADDRESS 127 South Mechanic Street	
3. NAME OF DECEASED (First) SILAS (Middle) ELBIN (Last)		4. DATE OF DEATH July 10 1956	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Apr. 20, 1870
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor & Odd Jobs		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Elbinsville, Penn.
13. FATHER'S NAME George Elbin		14. MOTHER'S MAIDEN NAME Naomi Lashley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-22-5283	17. INFORMANT & ADDRESS 127 So. Mechanic St. Ada Hamburg, Cumberland, Maryland
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <i>Carcinoma liver with metastases</i> ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerosis</i> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Unknown</i>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19e. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21c. WHERE DID INJURY OCCUR? (City or town) 133 Virginia Ave, Cumberland, Md (County) JULY 10 1956 (State)	
21d. TIME OF INJURY (Month) July (Day) 12 (Year) 1956 (Hour) M.	21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 20, 1956, to July 10, 1956, that I last saw the deceased alive on July 8, 1956, and that death occurred at 3 AM, from the causes and on the date stated above. SIGNATURE <i>Edmund L. Lom</i> DATE SIGNED <i>JULY 10 1956</i> ADDRESS <i>133 Virginia Ave, Cumberland, Md</i> 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial DATE THEREOF NAME OF CEMETERY OR CREMATORIUM M.D. LOCATION (City, town, or county) Allegany County, Md. (State) July 12, 1956 Pleasant Grove Cem.			
24. REC'D BY REGISTRAR July 12, 1956	REGISTRAR'S SIGNATURE Winter R. Hafer, M.D.		
25. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md. ADDRESS			

Within corporate limits

INSTRUCTIONS

To ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06733

CERTIFICATE OF DEATH

6745

Reg. Dist. No. 4

1. PLACE OF DEATH

COUNTY Allegany
CITY (If outside corporate limits, write RURAL
OR end give nearest town)
TOWN Cumberland
HOSPITAL OR
INSTITUTION OR
STREET ADDRESS Allegany County Infirmary

MARYLAND

LENGTH OF STAY
(in this place)
1/18/56

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN Cumberland
STREET ADDRESS (if rural give location)
23 New Hampshire Avenue

3. NAME OF DECEASED (Type or Print)

(First) (Middle) (Last)
(Evans) Sarah B. Evans

5. SEX Female

6. COLOR OR
RACE White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) Widow

8. DATE OF BIRTH 1875
3/8/1875 XX

9. AGE at birthday
81 yrs.

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired) Housewife

10b. KIND OF BUSINESS
OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country)
Frostburg, Maryland

12. CITIZEN OF WHAT
COUNTRY?
U. S. A.

13. FATHER'S NAME

Charles Brode

14. MOTHER'S MAIDEN NAME

Catherine Gerlock

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, No, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

None

17. INFORMANT & ADDRESS P. O. Box 599

Allegany County Infirmary Records

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422-1 IMMEDIATE CAUSE

(A)

Chronic Myocarditis

INTERVAL BETWEEN
ONSET AND DEATH

?

ANTECEDENT CAUSE(S)
DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

DUE TO

(B)

General arteriosclerosis.

?

DUE TO

(C)

Cerebral Hemorrhage

?

Chronic nephritis

?

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN
ONSET AND DEATH

?

21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
M. While at work Not while at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/18/56 to 7/29/56, that I last saw the deceased

alive on 1/29/56 and that death occurred at M. from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED

Dr. James E. McLean

M. D. 149 Greene St., Cumberland, Md.

7/30/56
(State)

23. BURIAL, CREMATION
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county)

Burial

7/31/56

Rose Hill Cemetery

Cumberland, Maryland

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

July 31, 1956

Walter F. Frantz, M.D.

John J. Hafer, Cumberland, Maryland

Digitized by srujanika@gmail.com

BUREAU V.

1 AUG 1 1956

明人詩集卷之三

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										06734			
										Reg. Dist. No.			
1. PLACE OF DEATH a. COUNTY Allegany					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE W.Va. b. COUNTY Hampshire								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Old Town			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Augusta			d. STREET ADDRESS <i>85x-3</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 51					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First Asa	Middle Eskridge	Last Everett	4. DATE OF DEATH Month July Day 6 Year 1956								
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Sept 27-1888		9. AGE (In years from birthday) 67 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS.			
male		white		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired, machinist helper-B&O.R.Ry.					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) Shanks, W.Va.			
										12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jacob E. Everett					14. MOTHER'S MAIDEN NAME Amanda C. Swisher								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. 721-16-9550					17. INFORMANT Mrs. Parsy Davis, Old Town, Md.			
										Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Shock- PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage due to a fractured										INTERVAL BETWEEN ONSET AND DEATH sudden			
<i>812X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					DUE TO (b) skull, comminuted fracture of left femur & DUE TO (c) humorous also nose.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Walking, route 51, hit & run, near Old Town, Md.								
20c. TIME OF INJURY Hour 12.25 o.m. 7-6		Month, Day, Year 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 51		20f. (City or town) near Old Town Allegany		(County) (State) Md.			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>													
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED July 6-1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-8-1956		22c. NAME OF CEMETERY OR CREMATORIAL Wesley Chapel			22d. LOCATION (City, town, or county) Points, W. Va.						
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.					ADDRESS <i>Scribble</i>					24a. REC'D BY REGISTRAR July 8, 1956		24b. REGISTRAR'S SIGNATURE <i>Mrs. Pay Buckworth</i>	

MISSOURI STATE-POLICE DEPARTMENT OF HEALTH-REGISTRATION
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06735

6785

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MARYLAND Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First NORMAN	Middle GARLITZ	Last July 18, 1956
4. DATE OF DEATH Month July	Day 18	Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-10-1883
9. AGE (In years lost birthday) 72 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farming	11. KIND OF BUSINESS OR INDUSTRY own farm	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME George Garlitz	14. MOTHER'S MAIDEN NAME Nancy Durst	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 189-22-6902	
16. SOCIAL SECURITY NO. 189-22-6902		17. INFORMANT Mrs. Norman Garlitz, Rt. 2, Frostburg, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Branchial pneumonia		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 9, 1956 to July 18, 1956 , that I last saw the deceased alive on July 18, 1956 , and that death occurred at 4:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 48 Broadway, Frostburg, Md. DATE SIGNED 7-19-56			
ACTUAL SIGNATURE Hilda Jane Walters			
PHYSICIAN'S NAME (Type) Hilda Jane Walters, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-21-1956	22c. NAME OF CEMETERY OR CREMATORIUM Blocher Cemetery	22d. LOCATION (City, town, or county) (State) Garrett County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE 7-20-56
			24b. REGISTRAR'S SIGNATURE Mr. B. C. Price

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be left with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06736

DR. SIMONS

6746

CERTIFICATE OF DEATH

Reg. Dist. No.

Within corporate limits DR. SIMONS • 6746 CERTIFICATE OF DEATH Page 4
 Retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 HRS. 25 MIN.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CLARENCE		First E	Middle GEHR
4. DATE OF DEATH JULY 19, 1956		Month JULY	Day 19
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH AUG. 2, 1889
9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. rrt. Agent		10b. KIND OF BUSINESS OR INDUSTRY W.M. Railroad	11. BIRTHPLACE (State or foreign country) MARYLAND, Indian Springs U.S.A.
13. FATHER'S NAME JOHN GEHR		14. MOTHER'S MAIDEN NAME MARY COOK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W.I	17. INFORMANT MEMORIAL HOSPITAL-WARWICK & MEMORIAL AVES.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH 6 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO Coronary Occlusion			
DUE TO 420.1			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland, Md.
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7/1/56 , to 7/1/56 , that I last saw the deceased alive on 7/1/56 , and that death occurred at 11:35 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE George M. Simons M.D.		ADDRESS (Street, city or town, state) Cumberland, Md. 128 Summit St.	
PHYSICIAN'S NAME (Type) DR. GEORGE M. SIMONS		DATE SIGNED 7/2/1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/22/56	22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR July 22, 1956		24b. REGISTRAR'S SIGNATURE Franky M. D.	

88 BROWNTAIL—TRAILING-EDGE THINNING AND STATE-CHANGE PREDICTION

BUREAU V. S.
JUL 24 1956
REGELIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06737

Reg. Dist. No. 4

Within corporate limits

If any delay is necessary, please enter
the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be
retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation,
or removal.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		LENGTH OF STAY IN 1b 80 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 108 N. Smallwood St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Back yard at home.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Frederick		Middle J. Grabenstein		4. DATE OF DEATH July 7 1956			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 1-1870	
9. AGE (In years last birthday) 85		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Merchant		11. KIND OF BUSINESS OR INDUSTRY Meat Market		12. BIRTHPLACE (State or foreign country) Near Pitts	
13. FATHER'S NAME Justus Grabenstein		14. MOTHER'S MAIDEN NAME Margaret Mundy		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. R. Everstein, Cumberland, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Coronary sclerosis		INTERVAL BETWEEN ONSET AND DEATH ?			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		several years.			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Cumberland		(County) Md.		(State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H.V. Deming M.D.		DATE SIGNED July 7-1956		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> July 7-1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-10-1956		22c. NAME OF CEMETERY OR CREMATORIAL S.S. Peter & Paul Cem.		22d. LOCATION (City, town, or county) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR July 9 1956		24b. REGISTRAR'S SIGNATURE W.L. Tracy, M.D.	

WEDNESDAY EXAMINER DEPARTMENT OF DEFENSE

81

WEDNESDAY EXAMINER DEPARTMENT OF DEFENSE

BUREAU V.

JUL 10 1956

RECEIVED

Within corporate limits.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06738

6748

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 51 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 38 Grand Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
3. NAME OF DECEASED (Type or print) Richard		First Henry	Middle Guthridge
4. DATE OF DEATH Month July		Day 16	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Brakeman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Brownsville, Md.
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-09-3740	17. INFORMANT Mrs. Richard H. Guthridge, Cumberland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis -		INTERVAL BETWEEN ONSET AND DEATH immediate	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Art Subl. CVD		3 yrs	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 37 1/2 S. Centre Street
20f. (City or town) Cumberland, Md.		(County) Washington Co.	
(State) Md.			
21. I certify that I attended the deceased from 4/15/52 , 19, to 7/16/56 , 19, that I last saw the deceased alive on 3/14/56 , 19, and that death occurred at 37 1/2 S. Centre Street , Cumberland, Md., from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 122 S. Centre Street			
DATE SIGNED 7/17/56			
ACTUAL SIGNATURE Richard J. Williams, M.D.			
PHYSICIAN'S NAME (Type) Richard J. Williams, M.D. Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 19, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest
22d. LOCATION (City, town, or county) Cumberland, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.			
ADDRESS James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR July 18, 1956	24b. REGISTRAR'S SIGNATURE L. R. Frantz, M.D.

CERTIFICATE OF DEATH

BUREAU X-1
RECEIVED
9 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07773

Reg. Dist. No.

9

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY Allegany			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Pa.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Myersdale		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hafer Funeral Home			d. STREET ADDRESS 408 Lincoln Ave		
3. NAME OF DECEASED (Type or print) Charles Allen Hahn			First Charles	Middle Allen	Last Hahn
4. DATE OF DEATH July 27 1956	Month July	Day 27	Year 1956		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH July 2-1928	9. AGE (In years last birthday) 28 yrs.	IF UNDER 1YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman			10b. KIND OF BUSINESS OR INDUSTRY W.Md.R.Ry.	11. BIRTHPLACE (State or foreign country) Garrett, Pa.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Allen R. Hahn			14. MOTHER'S MAIDEN NAME Viola Fuller		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. 175-20-4486	17. INFORMANT (father)	Address Allen R. Hahn, Myersdale, Pa.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage due to a crushed 822X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. with severe brain injury, right side. (b) Auto accident. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) turned over. Premise excessive speeded, auto turned around twice &		
20c. TIME OF INJURY Hour 12.05 p.m.		Month, Day, Year 7-27 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway, Rt. 40	20f. (City or town) Frostburg, Allegany, Md.
(County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE H.V. Deming M.D.			DATE SIGNED		
EXAMINER'S NAME (Type) H.V. Deming M.D.			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 27-1956		
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF July 30-1956	22c. NAME OF CEMETERY OR CREMATORIAL Union Cemetery		
23. FUNERAL DIRECTOR'S SIGNATURE Price Funeral Home, Myersdale, Pa.		ADDRESS	24a. REC'D BY REGISTRAR Myersdale Pa.		
			24b. REGISTRAR'S SIGNATURE Mrs. Nancy A. Roe		

DEPARTMENT OF HUMAN-SERVICE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Case No. 1000

Date of Death

1956

Month Year

Year

State of Death

Place of Death

City State

Cause of Death

1. (Cause of Death) (Type in full name)
2. (Cause of Death) (Type in full name)

3. (Cause of Death) (Type in full name)
4. (Cause of Death) (Type in full name)

BUREAU N.Y.

AUG 13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06739

6797

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH o. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Allegany								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midlothian		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midlothian		d. STREET ADDRESS						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? / YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year				
Anthony				Harvey	July	25	19	56				
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH	9. AGE (In years lost birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.					
Male	White	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	March 9, 1879	77 yrs.	Months	Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Judge				10b. KIND OF BUSINESS OR INDUSTRY People's Court				11. BIRTHPLACE (State or foreign country) Midlothian				
13. FATHER'S NAME Robert Harvey				14. MOTHER'S MAIDEN NAME Mary Gibson				12. CITIZEN OF WHAT COUNTRY? U.S.A.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.				17. INFORMANT 40 Grant Street Frostburg, Md.				
				None				Mrs. Elmer Jones				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				<i>Arterio Sclerosis</i>				INTERVAL BETWEEN ONSET AND DEATH Several years 4 yrs				
				<i>Myocardial Insufficiency</i>								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. DEATH WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 1954 , 19, to July 25 , 1956, that I last saw the deceased alive on June 23 , 1956, and that death occurred at 2804 , from the causes and on the date stated above. ACTUAL SIGNATURE <i>WOMC Lane Md.</i> PHYSICIAN'S NAME (Type) <i>WOMC Lane Md.</i>										ADDRESS (Street, city or town, state) Frostburg july 25 Md. 1956	DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-28-56				22c. NAME OF CEMETERY OR CREMATORIUM Frostburg Memorial Park				22d. LOCATION (City, town, or county) Frostburg (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>B-H. Montague</i>				ADDRESS HAFER FUNERAL HOME E. MAIN, FROSTBURG, MD.				24a. REC'D BY REGISTRAR DATE 7-30-56				24b. REGISTRAR'S SIGNATURE <i>Mary H. Rose</i>

CERTIFICATE OF DEATH

1955

CHALMERS

JULIA M. CHALMERS

Wife

Died

1955

Cause of death

Disease

Date of death

Place of death

Name of physician

Name of hospital

Name of coroner

Name of funeral director

Name of embalmer

Name of mortician

Name of undertaker

Name of cemetery

Name of funeral home

Name of mortuary

Name of embalming

Name of funeral director

Name of embalmer

Name of mortician

Name of cemetery

Name of funeral home

Name of mortuary

Name of embalming

Name of funeral director

Name of embalmer

Name of mortician

Name of cemetery

Name of funeral home

Name of mortuary

BUREAU V.

AUG 1 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06740

CERTIFICATE OF DEATH

Reg. Dist. No.

M 02 60		1. PLACE OF DEATH a. COUNTY ALLEGANY	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA	b. COUNTY HARDY			
		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	c. LENGTH OF STAY IN 1b 20 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MOOREFIELD				
		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES	d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
		3. NAME OF DECEASED (Type or print)	First ETHEL	Middle J.	Last HEDRICK	4. DATE OF DEATH JULY 25 1956		
		5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 20, 1899	5. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Laborer in Poultry Dressing Plant		10b. KIND OF BUSINESS OR INDUSTRY Hardy County, W. Va.	11. BIRTHPLACE (State or foreign country) USA	12. CITIZEN OF WHAT COUNTRY? USA		
		13. FATHER'S NAME CLARK HEAVNER		14. MOTHER'S MAIDEN NAME Martha L. Heavner			Address	
		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 235-30-0123	17. INFORMANT Mrs. Nellie Ebert, Moorefield, West Virginia.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Cerebral Hemorrhage (c) DUE TO Hypertension vascular disease ? INTERVAL BETWEEN ONSET AND DEATH 5 July 1956		
MEDICAL CERTIFICATION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 5 July , 1956, to 25 July , 1956, that I last saw the deceased alive on 25 July , 1956, and that death occurred at 6:50A.M. from the causes and on the date stated above. ACTUAL SIGNATURE W. A. VAN ORMER		ADDRESS (Street, city or town, state) Moorefield, W. Va.				DATE SIGNED 25 July 56		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-27-56	22c. NAME OF CEMETERY OR CREMATORIUM Oliver Cemetery	22d. LOCATION (City, town, or county) Moorefield, West Virginia.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Theresa's Funeral Home		ADDRESS Maryfield	24a. REC'D BY REGISTRAR DATE July 26, 1956	24b. REGISTRAR'S SIGNATURE W. L. Tracy, M.D.				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ET DICO VOBIS—PISSARO TANTO BIZARRO E STAR QUASE SEMPRE

BUREAU Y.

Jul 27 1956

REGELIV ED

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY A 1162	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RAWLINGS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First IVY	Middle S	Last HIGGS	4. DATE OF DEATH JULY 17 1956	Month JULY	Day 17	Year 1956
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 9, 1887	9. AGE (In years lost birthday) 68 yrs.	IP UNDER 1 YEAR Months 68	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME THOMAS MEDLIN			14. MOTHER'S MAIDEN NAME LENA LAWRENCE				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Franklin Sherwood,		Address Rawlings, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		<i>Coronary Embolism</i>		INTERVAL BETWEEN ONSET AND DEATH Sudden			
DUE TO		<i>Coronary Artery Disease</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 260x Diabetes Mellitus							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Diabetes Mellitus					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Forest Park, Ill.	(County) Forest Park, Ill.	(State) Ill.	
21. I certify that I attended the deceased from 6-18-1956 , to 7-17-1956 , that I last saw the deceased alive on 7-17-1956 , and that death occurred at 8:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) W. F. Williams, Cumberland, Md. DATE SIGNED 7-18-56							
ACTUAL SIGNATURE W. F. Williams, Cumberland, Md.							
PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July, 20, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery		22d. LOCATION (City, town, or county) Forest Park, Ill. (State) Ill.			
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.				ADDRESS Charles L. George, Cumberland, Md.		24a. REC'D BY REGISTRAR July 29, 1956	24b. REGISTRAR'S SIGNATURE Winter R. Frank, M.D.

processes, and the results of the analysis.

BUREAU Y-8

July 23 1956

REFELIV ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6751

CERTIFICATE OF DEATH

06742

Reg. Dist. No.

Within corporate limits

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		d. STREET ADDRESS 718 Yale St.,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 718 Yale St.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First ROY	Middle OLIVER	Last HINKLE	4. DATE OF DEATH July 2,	Month July	Day 2	Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH May 26, 1895	9. AGE (In years lost birthday) 61 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME James O. S. Hinkle				14. MOTHER'S MAIDEN NAME Susan Wilson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-7219		17. INFORMANT Mrs. Mamie Hinkle 718 Yale St., Cumb. Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (a), stating the underlying cause (a), stating the underlying cause (a), (b) DUE TO (c)		<i>Coronary Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH 5 minutes		<i>Coronary Artery Disease</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 1205 A.M.		(County) Cumberland, Md.	(State) Md.
21. I certify that I attended the deceased from 6/15/56 to 7/2/56 , that I last saw the deceased alive on 6/15/56 , and that death occurred at 1205 A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Richard J. Williams, M.D.</i>		ADDRESS (Street, city or town, state) 122 So. Centre St., Cumberland, Maryland							
PHYSICIAN'S NAME (Type) Richard J. Williams, M.D.		DATE SIGNED July 3, 1956							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/4/56		22c. NAME OF CEMETERY OR CREMATORIAL Greenmount Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Maryland							
				24a. REC'D BY REGISTRAR July 3, 1956		24b. REGISTRAR'S SIGNATURE W. E. Tantz, M.D.			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06743

Reg. Dist. No. 9

1.		PLACE OF DEATH o. COUNTY		6787 Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b		o. STATE Pa. b. COUNTY Somerset	
		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		d. STREET ADDRESS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural) Rt. #3 Myersdale	
		3. NAME OF DECEASED (Type or print)		First Wayne	Middle Joseph	Last Hostetler	4. DATE OF DEATH July 29 1956
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Feb. 20-1953	9. AGE (In years last birthday) 3 yrs.
				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			IF UNDER 1YEAR Months Days Hours Min.
		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Myersdale, Pa.	
						12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME C. Carl Hostetler				14. MOTHER'S MAIDEN NAME Verna Catherine Clark			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT (father) C. Carl Hostetler, Myersdale, Pa.		Address R.F.D. #3	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Asphyxia due to					
9360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Strangulation (accidental) sudden					
		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury, how it occurred, and how it ended.) Unknown manner, found with head through loop of baling cord, which hung on a nail.					
20c. TIME OF INJURY Month, Day, Year Hour 3.15 p.m. 7-29 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rural, Rt. #3 (County) (State)			
				In shed, at home Myersdale, Somerset Pa.			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H. V. Deming M.D.		DATE SIGNED					
EXAMINER'S NAME (Type) H. V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 29-1956					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-1-56		22c. NAME OF CEMETERY OR CREMATORIAL Finzel Cemetery		22d. LOCATION (City, town, or county) (State) Finzel Md.	
23. FUNERAL DIRECTOR'S SIGNATURE BURGER H. Montsant		ADDRESS 2AFER FUNERAL HOME 23 E. Main, Frostburg		24a. REC'D BY REGISTRAR DATE 8-1-56		24b. REGISTRAR'S SIGNATURE D. Dailey N. Ross	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

UG 5 1956

RECEIVED

UG 5 1956

BUREAU A.S.

1
Within 8 hours after death

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

INSTRUCTIONS

The bottom copy may be retained by the hospital or attending physician.

VS AISC 155 10K

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06744

CERTIFICATE OF DEATH

6752

Reg. Dist. No. 4

1. PLACE OF DEATH

COUNTY Allegany

CITY (If outside corporate limits, write RURAL
OR
and give nearest town)

TOWN Cumberland,

MARYLAND

LENGTH OF STAY
(in this place)

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Memorial Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Cresaptown,

STREET ADDRESS
(If rural give location)

Cresap Park

3. NAME OF DECEASED (Type or Print)

(First) DELLA

(Middle) FLORENCE

(Last) KILE

4. DATE (Month) (Day) (Year)
OF DEATH July 23, 1956

5. SEX Female

6. COLOR OR
RACE White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) Widowed

8. DATE OF BIRTH
January 8, 1869

9. AGE last birthday
87 yrs.

IF UNDER 1 YEAR
Months Days Hours Min.

10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired) Housewife

10b. KIND OF BUSINESS
OR INDUSTRY
Own home

11. BIRTHPLACE (State or foreign country)
Pendleton Co., W. Va.

12. CITIZEN OF WHAT
COUNTRY?
U. S.

13. FATHER'S NAME

Morgan D. Lambert

14. MOTHER'S MAIDEN NAME

Martha Ann Simmons

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) No. (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

None

17. INFORMANT & ADDRESS

Mr. Jesse H. Simmons Kidgely, W. Va.

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X IMMEDIATE CAUSE

(A)

Cerebral vascular accident

ANTECEDENT CAUSE(S) DUE TO
DISEASES OR CONDITIONS, IF ANY, (B)
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO
(C)

Cerebral sclerosis

INTERVAL BETWEEN
ONSET AND DEATH
3 weeks

5 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19e. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES NO

21e. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While Not while
at work at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-30, 1956, to 7-23-, 1956, that I last saw the deceased alive on 7-23-, 1956, and that death occurred at 7:30 A.M. from the causes and on the date stated above.

SIGNATURE

Lega W. Bailes

ADDRESS (Street, city, town, state)

DATE SIGNED

M.D. 62 Greene St., Cumberland, Md. 7/23/56

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county)

(State)

Burial

7/25/56

Cedar Hill Cemetery

Franklin, W. Va.

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

July 23, 1956

Winters R. Frank, M.D.

Charles L. George Cumberland, Maryland

WILSON COUNTY, TENNESSEE
DEPARTMENT OF MOTOR VEHICLES

CERTIFICATE OF DEATH

BUREAU V. S.

JUL 24 1956

RECEIVED



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

6753

Reg. Dist. No. 4

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN		MARYLAND LENGTH OF STAY (In this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		COUNTY Allegany Mt. Savage (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS		6	STREET ADDRESS		
Sylvan Retreat Furnace St					
3. NAME OF DECEASED (First) Joseph Phillip Kirby			4. DATE OF DEATH 7-25-1956		
(Middle)			(Month) (Day) (Year)		
(Last)					
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W	8. DATE OF BIRTH 12-31-1872	9. AGE last birthday 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired laborer			10b. KIND OF BUSINESS OR INDUSTRY brick yard	11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Phillip Kirby			14. MOTHER'S MAIDEN NAME Sarah Metz		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO. 213-10-9122	17. INFORMANT & ADDRESS Roy Kirby, Mt. Savage, Md.	
18. MEDICAL CERTIFICATION					
<p>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p>592X IMMEDIATE CAUSE (A) <i>Chronic myocardial deterioration</i></p> <p>ANTECEDENT CAUSE(S) DUE TO (B) <i>General arteriosclerosis</i></p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Chronic nephritis.</i></p> <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</p> <p><i>Tenile psychosis.</i></p>					
INTERVAL BETWEEN ONSET AND DEATH ? ? ?					
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
<p>22. I hereby certify that I attended the deceased from <i>July 7, 1956</i>, to <i>July 25, 1956</i>, that I last saw the deceased alive on <i>July 24, 1956</i>, and that death occurred at <i>M.</i> from the causes and on the date stated above.</p> <p>SIGNATURE <i>James Z. McLean Jr.</i> ADDRESS <i>49 Greene St.</i> DATE SIGNED <i>7-25-56</i></p>					
23. BURIAL CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF 7-27-56	NAME OF CEMETERY OR CREMATORIAL Methodist Cemetery	LOCATION (City, town, or county) Mt. Savage, Md. (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>W. P. Durst, M.D.</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. R. Durst, Frostburg, Md.		
DATE 7-27-56					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06746

Reg. Dist. No.

8

6798

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Gilmore

c. LENGTH OF STAY IN 1b

47 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

R.F.D. #1-Frostburg, Md.

3. NAME OF
DECEASED
(Type or print)

First Middle Last
Francis Mae Catherine Knepp

4. SEX

Female

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

May 21-1909

9. AGE (in years
last birthday)

47 yrs.

10. IF UNDER 1YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Gilmore, Md.

11. BIRTHPLACE (State or foreign country)

Gilmore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Ralph Fazenbaker

14. MOTHER'S MAIDEN NAME

Fannie Metz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

216-07-2701

17. INFORMANT

(husband) Charles Knepp, Gilmore, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY;
IMMEDIATE CAUSE (a)

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH

sudden

420.1

DUE TO

Conditions, if any, which
gave rise to Immediate cause
(a), stating the underlying
cause lost.

(b)

Coronary sclerosis

?

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

H.V. Deming M.D.

M.D. CHIEF MEDICAL EXAMINER

DATE SIGNED

EXAMINER'S
NAME (Type)

H.V. Deming M.D.

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

July 18-1956

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

7/20/1956

22c. NAME OF CEMETERY OR CREMATORIUM

Oak Hill Cemetery

22d. LOCATION (City, town, or county)

Lonaconing, MD.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

George Eichhorn, Lonaconing, MD.

ADDRESS

24a. REC'D BY REGISTRAR

DATE

24b. REGISTRAR'S SIGNATURE

DATE

7/23/56

Jeanette M. Bodd

RECEIVED

BUREAU V. 5

JUL 25 1956

DR. JAMES

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06747

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 11 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital				d. STREET ADDRESS 133 SOUTH LIBERTY ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY		First ELIZABETH	Middle KORNHOFF	Last KORNHOFF	4. DATE OF DEATH Month JULY Day 8 Year 1956	Month JULY Day 8 Year 1956	IF UNDER 1 YEAR Months Days Hours Min.
S. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/20/1868	9. AGE (In years lost 88 Birthday) yrs. 88	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CONRAD CASPERLINE				14. MOTHER'S MAIDEN NAME CAROLINE SHILLING		Address MEMORIAL AVE., CUMBERLAND,	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				<i>Congestive Heart failure</i>		INTERVAL BETWEEN ONSET AND DEATH 2 day	
				<i>Atherosclerosis and severe Anemia</i>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6-20 , 19 56 to 7-8 , 19 56 , that I last saw the deceased alive on 7-8 , 19 56 , and that death occurred at 8:55 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) William P. James, M.D.		DATE SIGNED 7-10-56	
ACTUAL SIGNATURE William P. James, M.D.							
PHYSICIAN'S NAME (Type) William P. James, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 10, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE July 10, 1956		24b. REGISTRAR'S SIGNATURE W. Frank, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral-director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK - BUREAU - 18

CERTIFICATE OF DATE

7-11

1956

RECEIVED

RECEIVED - DEPT. OF STATE - NEW YORK CITY - JULY 11, 1956

7-11-56

TELETYPE - 7-11-56

A.C.

7-11-56

7-11-56

7-11-56

RECEIVED

7-11-56

RECEIVED - DEPT. OF STATE - NEW YORK CITY - JULY 11, 1956

BUREAU N.Y.

JUL 11 1956

RECEIVED

6755

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		b. COUNTY Allegany	
c. LENGTH OF STAY IN lb 3/16/55		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 1300 Bedford Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Katherine	Middle E.	Last Larkin
4. DATE OF DEATH	Month July	Day 24,	Year 19 56
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/3/1869
9. AGE (In years last birthday) 86	10. IF UNDER 1 YEAR Months 86	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
13. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Warfersburg, Penna.	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Thomas E. Shives		14. MOTHER'S MAIDEN NAME Mary Richards	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Allegany County Infirmary Records		Address P.O. Box 599	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
260X DUE TO Pulmonary Congestion INTERVAL BETWEEN ONSET AND DEATH 72 hrs			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) ?			
DUE TO Chronic Myocarditis ?			
(c) ?			
Diseases Mellitus ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
26. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Senile arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
p.m.		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/16/55 , 19, to 7/24/56 , 19, that I last saw the deceased alive on 7/24/56 , 19, and that death occurred at 2:20A M , from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean		ADDRESS (Street, city or town, state) 19 Greene St.	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		DATE SIGNED 7/24/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-26-56	
22c. NAME OF CEMETERY OR CREMATORIAL Camp Hill Cemetery		22d. LOCATION (City, town, or county) (State) Paw Paw, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR July 26, 1956	
		24b. REGISTRAR'S SIGNATURE W.L. Frank Jr. M.D.	

RECEIVED - MAIL ROOM - STANFORD UNIVERSITY

REGISTRATION CARD

WAGNER

Patricia M.

Address

U.S. AIR FORCE

Businessman

2225 N.

1st Avenue

Desoto Brother 0050

Commercial Company

First

Street

Entrance

80

REGIMENT

801 1st Street

Wright-Patterson Air Force Base

Division

Alameda City

Serial # 20007

P.O. Box 528

Desoto Brother Commercial Company

BUREAU

JUL 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limit.

06749

6756

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 39 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 401 E. Oldtown Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Robert	Middle Lathrum	Last 4. DATE OF DEATH July 16 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1864
9. AGE (In years lost birthday) 92 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Loudoun County, Va.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. R. Kirk Lathrum, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT		INTERVAL BETWEEN ONSET AND DEATH	
331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) OLD AGE DUE TO (c) ARTERIOLOSCLEROTIC VASCULAR DISEASE			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JULY , 19 56 , to JULY , 19 56 , that I last saw the deceased alive on 7/16 , 19 56 , and that death occurred at 10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) G. Overton Himmelwright, M.D.			
ACTUAL SIGNATURE <i>G. Overton Himmelwright, M.D.</i>	DATE SIGNED 7/17/56		
PHYSICIAN'S NAME (Type) G. Overton Himmelwright, M.D.	133 VIRGINIA AVENUE		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 18, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest	22d. LOCATION (City, town, or county) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR July 18, 1956	24b. REGISTRAR'S SIGNATURE W. Frent, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ST. JEROME TERRACE - PITTIEH FOR THE MOUNTAIN STATE GRANT PAGE

BUREAU V. S.

July 19 1956

REGELVÉD

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06750

CERTIFICATE OF DEATH

6757

Reg. Dist. No. 4

INSTRUCTIONS

Vital statistics reportable limits

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. After the death certificate has been executed by the attending physician or hospital, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After the death certificate has been executed by the attending physician or hospital, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN Cumberland		STATE Maryland COUNTY Allegany CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, rural STREET ADDRESS Rt. 3, Hazen Road	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary			
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) Florence		(Month) July (Day) 26, (Year) 1956	
(Middle) B.		(Last) Leisure	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 6/14/1885
9. AGE last birthday 71 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY Own Home	12. BIRTHPLACE (State or foreign country) Berryville, Virginia
13. FATHER'S NAME Eugene Russell	14. MOTHER'S MAIDEN NAME Nellie Brown	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS P. O. Box 599 Allegany County Infirmary Records	
18. MEDICAL CERTIFICATION			
<p>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.2 IMMEDIATE CAUSE (A) Pulmonary Hypostasis 24 hrs ANTECEDENT CAUSE(S) DUE TO Chronic bronchitis > DISEASES OR CONDITIONS, IF ANY, (B) giving rise to the above cause cerebrovascular disease ? STATING UNDERLYING CAUSE LAST. DUE TO (C) Chronic nephritis ></p>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7/14/56, 19, to 7/26/56, 19, that I last saw the deceased alive on 7/26/56, 19, and that death occurred at 4:45 P.M. from the causes and on the date stated above.			
SIGNATURE Dr. J. E. McLean		ADDRESS (Street, city, town, state) M.D. 49 Greene St., Cumberland, Md.	
DATE SIGNED 7/27/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF July 29 1956	NAME OF CEMETERY OR CREMATORIAL Zion Memorial Burial Park	LOCATION (City, town, or county) Cumberland, Md. (State)
24. REC'D BY REGISTRAR July 28, 1956	REGISTRAR'S SIGNATURE W.R. Frank, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE J. H. Haught	
ADDRESS Cumberland, Md.			

CERTIFICATE OF DEATH

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
JULY 31 1956
SEARCHED INDEXED SERIALIZED FILED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASH. 25, D. C.
SEARCHED INDEXED SERIALIZED FILED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASH. 25, D. C.

BUREAU V. 5

SEARCHED INDEXED SERIALIZED FILED
JUL 31 1956

RECEIVED

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached far enough from the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 14 Film G200 7-21-56 61
~~SECRET~~

06751

Reg. Dist. No.

6799

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. # 6 Cumberland		c. LENGTH OF STAY IN lb 10 Mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. # 6 Cumberland				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Locust Grove		d. STREET ADDRESS Locust Grove		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) MARY		First ELIZABETH	Middle LEASURE	Last July	4. DATE OF DEATH 1882	Month 14	Day 1956	Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 2, 1882	9. AGE (In years lost birthday) 74	IF UNDER 1 YEAR Months 74	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Galipolis, Ohio		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Otis Snyder				14. MOTHER'S MAIDEN NAME Lucille (Last name unknown)				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Walter S. Leasure Rt. # 6 Cumberland, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetes Mellitus</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>10 days</i>								
INTERVAL BETWEEN ONSET AND DEATH causes								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Clay E. Durrett	(County) M.D.	(State) 236 Virginia Ave.
21. I certify that I attended the deceased from Jan. 1956 , to July 14, 1956 , that I last saw the deceased alive on July 1956 , and that death occurred at 11:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 236 Virginia Ave.								
DATE SIGNED Clay E. Durrett								
ACTUAL SIGNATURE Clay E. Durrett		PHYSICIAN'S NAME (Type) Dr. Clay E. Durrett						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/17/56		22c. NAME OF CEMETERY OR CREMATORIUM Fellowship Cem.		22d. LOCATION (City, town, or county) (State) Centreville, Penna.		
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George ADDRESS Cumberland, Md.								
24a. REC'D BY REGISTRAR July 17, 1956					24b. REGISTRAR'S SIGNATURE W. Keenly, M.D.			

AT THE ONCE IS ONE OF THE MOST EXPENSIVE IN THE WORLD.

BONALD A. L.

Digitized by srujanika@gmail.com

DECEMBER 2012 • VOL 40 / NO 12 • JOURNAL OF CLIMATE

BUREAU V. S.

Jul 19 1956

REGEL V ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06752

Within corporate limits
6758

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 810 EDGEWOOD DRIVE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
3. NAME OF DECEASED (Type or Print) WALTER		First GEORGE	Middle LEIBRANT
4. DATE OF DEATH JULY 30		Last LEIBRANT	Month Day Year 19 56
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 19, 1883
9. AGE (In years lost birthday) 73 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0
13. FATHER'S NAME GEORGE LEIBRANT	14. MOTHER'S MAIDEN NAME ELIZABETH RUED	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 214 05 4957		17. INFORMANT Mrs. Nina E. Leibrant, Cumberland, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 45 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 30, 1956 , to July 30, 1956 that I last saw the deceased alive on July 30, 1956 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 49 Green St Cumberland, Md. DATE SIGNED 7/30/56	
ACTUAL SIGNATURE L.B. Matthews M.D.		PHYSICIAN'S NAME (Type) L.B. Matthews M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 1, 1956	22c. NAME OF CEMETERY OR CREMATORIY Hill Crest Cemetery	22d. LOCATION (City, town, or county) Cumberland, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Md.		24a. REC'D BY REGISTRAR 8/1/56	24b. REGISTRAR'S SIGNATURE WR Rantz, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

AUG 2 1956

REGELVET

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6800

CERTIFICATE OF DEATH

116753

Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Cumberland, rural		c. LENGTH OF STAY IN 1b 40 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.D.#5, Cumberland, rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Winchester Road, R. F. D. #5		d. STREET ADDRESS Winchester Road, R.F.D. #5		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOHN	Middle E.	Last LEWIS	4. DATE OF DEATH	Month 7	Day 4	Year 19 56
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1888 2 - 10 -	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Own business		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Lewis		14. MOTHER'S MAIDEN NAME Mary Thomas					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-34-4400		17. INFORMANT Mrs. Sarah Lewis, Cumberland, Md.		R.D.#5, Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerosis		DUE TO 260 X		INTERVAL BETWEEN ONSET AND DEATH 1 year			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. arteriosclerosis		DUE TO (b) arteriosclerosis		2 years			
		DUE TO (c) diabetes		3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5 Queen St. Cumberland, Md.		(County) (State) Md.	
21. I certify that I attended the deceased from 3-2- , 19 56 , to 7-4- , 19 56 , that I last saw the deceased alive on 7-1- , 19 56 , and that death occurred at 5 Queen St. Cumberland, Md. , from the causes and on the date stated above. ACTUAL SIGNATURE Lewis				ADDRESS (Street, city or town, state) 5 Queen St. Cumberland, Md.		DATE SIGNED 7-5-66	
PHYSICIAN'S NAME (Type) LEMS BRINGS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7 - 7 - 56		22c. NAME OF CEMETERY OR CREMATORIUM Frostburg Memorial Park Frostburg		22d. LOCATION (City, town, or county) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE B. H. Montesant		ADDRESS HAFER FUNERAL HOME 23 E. MAIN FROSTBURG		24a. REC'D. BY REGISTRAR July 7, 1956		24b. REGISTRAR'S SIGNATURE W.H. Frantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: **Page 3** should be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, **Page 3** should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEVADA STATE DEPARTMENT OF HEALTH - GALLIVAN

CERTIFICATE OF DEATH

0.192

BUREAU V. 8

JUL 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06754

6759

CERTIFICATE OF DEATH

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY PENNSYLVANIA		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		c. LENGTH OF STAY IN 1b 24 HRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND Rural, nr. Hyndman		d. STREET ADDRESS Rt. 1 Hyndman, Pa. 111 LADING AVE		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS Rt. 1 Hyndman, Pa. 111 LADING AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MARY		First MARY	Middle ALICE	Last LEWIS	4. DATE OF DEATH MARCH 26, 1906	Month JULY	Day 31	Year 1956
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 26, 1906		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME CHARLES HITCHINS				14. MOTHER'S MAIDEN NAME CATHERINE SHELL				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Rt. 1 Edward Lewis, Hyndman, Pennsylvania		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1		DUE TO Myocardial Failure		INTERVAL BETWEEN ONSET AND DEATH 48 hrs				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO Artery Cysto.						
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Virus infection						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) White at work						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Eckhart Cemetery		20f. (City or town) Cumberland		(County) Washington (State) Maryland
21. I certify that I attended the deceased from 3/16/56 to 3/31/56 , that I last saw the deceased alive on 3/26/56 , 19 56 , and that death occurred at 1:25 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE R. J. Williams M.D.				ADDRESS (Street, city or town, state) Cumberland		DATE SIGNED 3/31/56		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/3/56		22c. NAME OF CEMETERY OR CREMATORIUM Eckhart Cemetery		22d. LOCATION (City, town, or county) Cumberland		(State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS		24a. REC'D BY REGISTRAR Aug. 2, 1956		24b. REGISTRAR'S SIGNATURE Winter R. Frank, M.D.		

CERTIFICATE OF DEATH

100-10000

RECEIVED

REC'D

DEPARTMENT OF HEALTH - EDUCATION AND WELFARE

CHARTERED POLICE

BUREAU V.

AUG 3 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06755

Reg. Dist. No.

4

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be filed in the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for inspection or removal.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. ATSMES
SM 9/55

1. PLACE OF DEATH a. COUNTY		6891 Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		W.Va. b. COUNTY		Lewis	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb 6 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Weston		85x3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		211 Narrows Park		d. STREET ADDRESS		277 Cottage Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Anna	Middle Alice	Last Johnson	4. DATE OF DEATH	Month July	Day 5	Year 19 56	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
Female		white	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	Jan. 23-1873	83 yrs.	Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife		Own Home		Sweden		U.S.A.			
13. FATHER'S NAME		Johnson		14. MOTHER'S MAIDEN NAME		Louise- (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Narrows Park Address (daughter) Hannie Tiley, Cumberland, Md.			
		none							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH 2 yrs ?	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Uremia							
592X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Chronic nephritis						2 yrs	
		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED July 5-1956			
EXAMINER'S NAME (Type) H.V. Deming M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/7/56		22c. NAME OF CEMETERY OR CREMATORIUM Masonic Cemetery		22d. LOCATION (City, town, or county) Weston, West Virginia (State)			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS Hafer		24a. REG'D BY REGISTRAR July 6, 1956		24b. REGISTRAR'S SIGNATURE W.L. Frantz, M.D.			

BUREAU V. S

JUL 9 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Allegany</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt. # 1 Frostburg</u>		d. STREET ADDRESS <u>X</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Violet</u>		First <u>C.</u>	Middle <u>Loar</u>	Last <u></u>	4. DATE OF DEATH <u>July 9 1956</u>	Month <u>July</u>	Day <u>9</u>	Year <u>1956</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <u>August 8, 1877</u>	9. AGE (In years last birthday) <u>78 yrs.</u>	IF UNDER 1 YEAR Months <u></u>	IF UNDER 24 HRS. Days <u></u>	Hours <u></u>	Min. <u></u>	
8. ADDRESS <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>John Martin</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Jackson</u>		Address <u></u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Patient's Chart</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes Mellitus</u> DUE TO <u>260x</u> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Coronary Uterus</u> DUE TO (c) <u>Krebs</u>										INTERVAL BETWEEN ONSET AND DEATH <u>years 1</u> <u>(?) 1-2 months</u> <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)								
20c. TIME OF INJURY Hour a.m. p.m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Frostburg</u>	(County) <u>Wirt</u>	(State) <u>M.D.</u>		
21. I certify that I attended the deceased from <u>July 10 1956</u> to <u>July 10 1956</u> , that I last saw the deceased alive on <u>July 10 1956</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.										
ACTUAL SIGNATURE <u>B. M. Schindler</u>		ADDRESS (Street, city or town, state) <u>441 Greenfield</u> DATE SIGNED <u>July 10 1956</u>								
PHYSICIAN'S NAME (Type) <u>Blane M. Schindler, M.D.</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/12/1956</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>Memorial Park</u>		22d. LOCATION (City, town, or county) <u>Frostburg, M.D.</u>		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn, Lenacening, MD.</u>		ADDRESS <u></u>		24a. REC'D BY REGISTRAR <u>July 12, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Winter R. Frantz, M.D.</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU X-6

JUL 16 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

116757

6788

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN lb 38 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 231 Md. Ave		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport	
d. STREET ADDRESS 231 Md. Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lonnie First Franklin Middle Marsh, St/		4. DATE OF DEATH July 14 Month Day Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 Aug. 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Paper Mill	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		9. AGE (In years past birthday) yrs. 72	
13. FATHER'S NAME George H Marsh		14. MOTHER'S MAIDEN NAME Virginia Yowell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-24-1333	17. INFORMANT Lrwin Marsh-Westernport, Md. Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Degeneration, Not specified as Rheumatic		INTERVAL BETWEEN ONSET AND DEATH 2 Years	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-Sclerosis		2 Years	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 24, 1956, to July 14, 1956, that I last saw the deceased alive on July 14, 1956, and that death occurred at M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul A. Wilson, M.D.		ADDRESS (Street, city or town, state) Piedmont W.K.	
PHYSICIAN'S NAME (Type)		DATE SIGNED July 16, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/17/56	22c. NAME OF CEMETERY OR CREMATORIUM Philos Cem
22d. LOCATION (City, town, or county) Westernport		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE El. Boral		ADDRESS Westernport, Md.	24a. REC'D BY REGISTRAR DATE 7-16-56
		24b. REGISTRAR'S SIGNATURE Jean C Kelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

CITY STATION 500 STATE

1956

BUREAU U. S.

JUL 19 1956

RECEIVED

With corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06758

Reg. Dist. No. 4

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN lb

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

D.O.A. at the Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Randall

Langer

Martin

4. DATE
OF
DEATH

July

22

19 56

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED

B. DATE OF BIRTH

March 7-1951

9. AGE (In years
last birthday)5
yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Child

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert J. Martin

14. MOTHER'S MAIDEN NAME

Martha L. Langer

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

(father) Robert J. Martin, R.F.D. #2 Flintsto

Address

Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Shock, Pulmonary & intra-abdominal hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH
sudden

8/2X

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.DUE TO
(b) hago, ruptured spleen and multiple fracturesDUE TO
(c) of the extremities. Hit by an automobile.

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Standing along edge of road, hit by an auto.

20c. TIME OF INJURY Month, Day, Year
Hour

8

p.m.

7-22

1956

20d. INJURY OCCURRED
While at work Not while at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

Pleasant Valley

Cumberland

Allegany

Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .ACTUAL
SIGNATURE

H.V. Deming M.D.

DATE SIGNED

EXAMINER'S
NAME (Type)

H.V. Deming M.D.

M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

July 23-1956

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

July 25, 1956

22c. NAME OF CEMETERY OR CREMATORI

Zion Memorial Burial Park

22d. LOCATION (City, town, or county)

(State)

Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

John J. Hafer, Cumberland, Maryland.

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

STATE OF NEW YORK - BUREAU OF MOTOR VEHICLE
DEPARTMENT OF MOTOR VEHICLE - STATE OF NEW YORK

BUREAU

JUL 25 1956

RECEIVED

1 Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06759

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/551. PLACE OF DEATH
o. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland,

c. LENGTH OF STAY IN 1b
OR INSTITUTION

845 Mt. Royal Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

o. STATE

Maryland

b. COUNTY

Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland,

d. NAME OF HOSPITAL (If not in hospital, give street address)

d. STREET ADDRESS

845 Mt. Royal Ave.,

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
HENRY
HADDENLast
McCLOSKEY4. DATE
OF
DEATHMonth
JulyDay
1, 19 56

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
lost birthday)

IF UNDER 1 YEAR IF UNDER 24 HRS.

Male

White

WIDOWED DIVORCED

Sept. 29, 1881

Months

Days

Hours

Min.

10c. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Assist. Treas.

10b. KIND OF BUSINESS OR INDUSTRY

Kelly-Tire Co.

11. BIRTHPLACE (State or foreign country)

Salineville, Ohio

12. CITIZEN OF WHAT COUNTRY?

U. S.

13. FATHER'S NAME

Edward V. McCloskey

14. MOTHER'S MAIDEN NAME

Jennie Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give war or dates of service)

No.

16. SOCIAL SECURITY NO.

214-07-0833

17. INFORMANT

Mrs. Mary E. McCloskey 845 Mt. Royal Ave., Cumb. Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

422.2

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour

o. m.

19

p. m.

20d. INJURY OCCURRED

While
at work Not while
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 6/28/56, 19, to 7/1/56, 19, that I last saw the deceased alive on 7/1/56, 19, and that death occurred at 5 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)

R. J. Williams M. D.

Cumberland, Md.

DATE SIGNED

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

7/5/56

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

Akron, Ohio

23. FUNERAL DIRECTOR'S SIGNATURE

Charles L. George

Cumberland, Md.

24a. REC'D BY REGISTRAR

July 3, 1956

24b. REGISTRAR'S SIGNATURE

W.L. Frank, M.D.

81 BROWNSVILLE - TOWN OF THE HAMPTON STATE OWNERSHIP

REGELY ED **BUREAU Y.** 8
JUL 5 1956

1. *Bottom copy may be retained by the hospital or attending physician.*

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

INSTRUCTIONS

VS AISC 1-5 10M
The bottom copy may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06760

CERTIFICATE OF DEATH

6763

Reg. Dist. No. 4

1. PLACE OF DEATH

COUNTY

Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL
OR
end give nearest town)

TOWN Cumberland

LENGTH OF STAY
(in this place)

6/29/56

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland

COUNTY Allegany

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Cumberland

STREET
ADDRESS

(If rural give location)
157 Polk Street

3. NAME OF DECEASED (Type or Print)

(First) Elizabeth

(Middle)

(Last)

Metty

5. SEX

6. COLOR OR
RACE

Female White

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

Housewife

13. FATHER'S NAME

Unknown Holler

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, unk.) (If Yes, give war or dates of service)

No.

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

11. BIRTHPLACE (State or foreign country)

Stanton, Virginia

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 IMMEDIATE CAUSE (A)

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While at work Not while at work

21f. HOW DID INJURY OCCUR?

M.

22. I hereby certify that I attended the deceased from 6/29/56, 1956, to 7/13/56, 1956, that I last saw the deceased

alive on 7/13/56, 1956

and that death occurred at 9:05 P.M.

from the causes and on the date stated above.

SIGNATURE

Dr. James E. McLean

M.D.

49 Greene St., Cumberland, Md.

7/14/56

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

Burial

DATE THEREOF

7/16/56

NAME OF CEMETERY OR CREMATORIUM

Hilcrest Cem.

LOCATION (City, town, or county)

Cumb. Md.

(State)

24. REC'D BY REGISTRAR

July 16, 1956

REGISTRAR'S SIGNATURE

Walter L. Frantz, M.D.

Hanis Stein Inc.

Cumb. Md.

ADDRESS

111 W. Main St.

Cumb. Md.

25. FUNERAL DIRECTOR'S SIGNATURE

Walter L. Frantz, M.D.

Hanis Stein Inc.

Cumb. Md.

ADDRESS

111 W. Main St.

Cumb. Md.

THE ECONOMIST

— 10 —

卷之三

— 3 —

9. *Leptodora* *hirsutum* L. (Fig. 10) is a common species throughout the region.

卷之三

- 20 -

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卷之三

Other References

REFERENCES

Signaling

卷之三

For a detailed discussion of the various types of *in vitro* assays, see Chapter 10.

BUREAU A.

JUL 18 1956

Verne - 2011-0518

卷之三

DEPARTMENT OF THE ARMY, WASHINGTON, D. C.

2000-2001

With a corporate limit.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06761

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Dr. James. 6764

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellerslie		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First William	Middle Henry	Last Moyer	4. DATE OF DEATH	Month 7	Day 1	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1895	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months 60	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Moyer			14. MOTHER'S MAIDEN NAME Rachel Simons				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-7305		17. INFORMANT Memorial Hospital, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
INTERVAL BETWEEN ONSET AND DEATH leaves -							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1956 , to July 1, 1956 , that I last saw the deceased alive on July 1, 1956 , and that death occurred at 6:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4411 W. Centre St DATE SIGNED 7-2-56							
ACTUAL SIGNATURE William P. James M.D.							
PHYSICIAN'S NAME (Type) Dr. W. A. James							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 4, 1956		22c. NAME OF CEMETERY OR CREMATORIUM St Peter & Paul Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE G. J. Wright							
ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR July 3, 1956		24b. REGISTRAR'S SIGNATURE W. G. Frantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y.

1956 5 JUL

REFUGEE

CERTIFICATE OF DEATH

6802

Reg. Dist. No. 8

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 15-5 10-W

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY Allegany (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Robbins Street	STREET ADDRESS	Robbins Street
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) EMMA (Middle) M (Last) MURPHY		7/28/1956 19	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 3/3/ 1891
9. AGE last birthday 65 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		11. BIRTHPLACE (State or foreign country) Barton, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Merrbaugh	
14. MOTHER'S MAIDEN NAME Mary Russell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS John Murphy, Lenaconing, MD.	
18. MEDICAL CERTIFICATION (HUSBAND) Congestive Heart failure Atherosclerosis Acute gastro-enteritis		19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. et work		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from July 28, 1956, to July 28, 1956, that I last saw the deceased alive on July 28, 1956, and that death occurred at 8 p.m., from the causes and on the date stated above. SIGNATURE Leslie R. Miller. M.D. ADDRESS (Street, city, town, state) Lenaconing, MD. DATE SIGNED July 30, 1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7/31/1956 NAME OF CEMETERY OR CREMATORIUM Oak Hill Cemetery LOCATION (City, town, or county) (State) Lenaconing, MD.	
24. REC'D BY REGISTRAR DATE 8/2/56		REGISTRAR'S SIGNATURE Janette M. Boal 25. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lenaconing, MD. ADDRESS	

RECEIVED - DEPARTMENT OF STATE - WASH. D. C.

CLASSIFIED BY STADIRSSO

JOANNE MCGEE

JOANNE MCGEE

1956

1956

1956

BUREAU V. 2

UG 5 1956

RECEIVED

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6893

CERTIFICATE OF DEATH

06763
9

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rt. 1, Frostburg

c. LENGTH OF STAY IN lb

life

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rt. 1, Frostburg

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

July

Month
Day
Year

23, 19 56

5. SEX

male

6. COLOR OR RACE

white

WIDOWED DIVORCED 7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9-13-1872

9. AGE (In years
last birthday)
83 yrs.10. IF UNDER 1 YEAR
IF UNDER 24 HRS.
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

retired merchant

10b. KIND OF BUSINESS OR INDUSTRY

own grocery store

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

David Neilson

14. MOTHER'S MAIDEN NAME

Margaret Shaw

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

none

17. INFORMANT

James Neilson, Frostburg, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Urnia

INTERVAL BETWEEN
ONSET AND DEATH

3 days

450.0

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

DUE TO

(b)

DUE TO

(c)

DUE TO

(d)

DUE TO

(e)

DUE TO

(f)

DUE TO

(g)

DUE TO

(h)

DUE TO

(i)

DUE TO

(j)

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(k)

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DUE TO

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(hh)

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(ii)

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ACTUAL
SIGNATURE

John B. Davis, M.D., 2 Broadway, Frostburg, Md.

PHYSICIAN'S
NAME (Type)22b. DATE THEREOF
Burial 7-26-1956 F'bg. Memorial Park
22c. NAME OF CEMETERY OR CREMATORIUM
22d. LOCATION (City, town, or county)
Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS
J. R. Durst, Frostburg, Md.
24a. REC'D BY REGISTRAR
DATE 7-26-56
24b. REGISTRAR'S SIGNATURE
See Darcy N. Rose

WISCONSIN STATE DEPARTMENT OF HEALTH - SECTION 18

CERTIFICATE OF DEATH

88-3

Name of deceased		Date of birth	
John W. Gandy		1888-08-16	
Address at time of death		Cause of death	
1000 N. 10th Street, Milwaukee, Wisconsin		Died of heart attack	
Place of death		Time of death	
Home		10:00 P.M.	
Name and address of physician or hospital		Name and address of coroner	
Milwaukee General Hospital, Milwaukee, Wisconsin		Milwaukee County Coroner, Milwaukee, Wisconsin	
Name and address of funeral director		Name and address of embalmer	
Milwaukee Mortuary, Milwaukee, Wisconsin		Milwaukee Mortuary, Milwaukee, Wisconsin	
Name and address of informant		Signature of physician or coroner	
John W. Gandy, Milwaukee, Wisconsin		John W. Gandy	
Relationship to deceased		Signature of informant	
Son		John W. Gandy	
Date of report			
Jul 31 1956			
BUREAU OF HEALTH			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06765
9

Reg. Dist. No.

1		Item 1 Film G201 8-6-56 et			
6805					
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE			
Allegany		MARYLAND		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Allegany				Frostburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Big Savage Refactory Corp., Allegany, Md.		231 Welsh Hill			
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH	Month Day Year
Joseph		Elmer	Perdew	July	23 19 56
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
male		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 5-1885	71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer-Big Savage Refactory Corp.				Flintstone, Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Asberry Perdew		Emily Johnson		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no		213-09-6450 (son)		Robert Perdew, Frostburg, Md.	
Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					
Coronary occlusion					
INTERVAL BETWEEN ONSET AND DEATH sudden					
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)					
Coronary sclerosis					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> July 23-1956			
EXAMINER'S NAME (Type) H.V. Deming M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-26-56		22c. NAME OF CEMETERY OR CREMATORIUM Queens Point Cemetery	
				22d. LOCATION (City, town, or county) Keyser, W. Va.	
22e. LOCATION (State)					
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.					
ADDRESS					
24a. REC'D BY REGISTRAR 7-26-56 J. R. Durst, Frostburg, Md.					
24b. REGISTRAR'S SIGNATURE <i>Daisy N. Rose</i>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU Y. S.

JUL 31 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6765

CERTIFICATE OF DEATH

06766

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 30 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat		e. IS RESIDENCE ON A FARM? / YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lucy		First - Middle Rizer	4. DATE OF DEATH Month July Day 7, 1956 Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Henery Pape		14. MOTHER'S MAIDEN NAME Elizabeth Coppage	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Mary Nine - Cemetery Road
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { b. DUE TO c. Chronic Myocardial Degeneration Cerebral Arteriosclerosis Chronic Zephritis Senile psychosis			
INTERVAL BETWEEN ONSET AND DEATH ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Severe hypertension			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 6, 1956 , to July 7, 1956 , that I last saw the deceased alive on July 7th, 1956 , and that death occurred at 76 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greece St. DATE SIGNED 7-7-56			
ACTUAL SIGNATURE James E. McLean, M.D.			
PHYSICIAN'S NAME (Type) James E. McLean, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 10, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Frostburg Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home, Frostburg, Maryland.		ADDRESS	24a. REC'D BY REGISTRAR DATE July 10, 1956
			24b. REGISTRAR'S SIGNATURE W.R. Hantz, M.D.

BUREAU V. S.

JUL 11 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06767

Reg. Dist. No.

Within corporate limits

CERTIFICATE OF DEATH

6766

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 22 mins.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl Roby		First	Middle
4. DATE OF DEATH July 25	Month	Day	Year 19 56
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1956
9. AGE (In years lost birthday) yrs. 0	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0
13. FATHER'S NAME James L. Roby, Jr.	14. MOTHER'S MAIDEN NAME Wanda Settle		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address Mrs. James L. Roby, Sr., Cumberland, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 761.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) BREACH DELIVERY INTERVAL BETWEEN ONSET AND DEATH 22 min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Moderate difficulty in aftercoming head.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M., from the causes and on the date stated above. ACTUAL SIGNATURE W.R. Hedges, M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 26, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Martin's Cemetery	22d. LOCATION (City, town, or county) (State) Little Orleans, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE 7/26/56	24b. REGISTRAR'S SIGNATURE W.R. Hedges, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF JUSTICE - FEDERAL BUREAU OF INVESTIGATION

CERTIFICATE OF DEATH

DECEASED PERSON
NAME: JAMES EARL RAY
DATE OF DEATH: 4-24-68

DEATH DATE:

TIME OF DEATH:

PLACE OF DEATH:

CAUSE OF DEATH:

METHOD OF DEATH:

AGE AT DEATH:

SEX:

RACE:

HEIGHT:

WEIGHT:

HAIR COLOR:

EYES COLOR:

BLOOD GROUP:

RELIGION:

EDUCATION:

OCCUPATION:

EMPLOYER:

ADDRESS:

CITY:

STATE:

ZIP CODE:

PHONE NUMBER:

TELEGRAMS:

TELETYPE:

TELEFAX:

FACSIMILE:

TELETYPE:

TELEFAX:

FACSIMILE:
RECEIVED
BUREAU
JUL 30 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06768

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH o. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 7 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MINNIE	First U	Middle UDY	Last RODDA		
4. DATE OF DEATH July 9, 1956	Month July	Day 9	Year 1956		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-22-1874		
9. AGE (In years lost birthday) 82 yrs.	10. IF UNDER 1 YEAR Months 82	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Frederick Udy	14. MOTHER'S MAIDEN NAME Hannah Wardell				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 219-03-9516F	17. INFORMANT Mrs. Mildred Myers, Frostburg, Md.	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency DUE TO 443x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Several years			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1955	20f. (City or town) Frostburg	(County) W. Va.	(State) W. Va.
21. I certify that I attended the deceased from July 9, 1956 to July 9, 1956 , that I last saw the deceased alive on July 8, 1956 , and that death occurred at 2 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Womc Lane	ADDRESS (Street, city or town, state) 167 E Main			DATE SIGNED July 10, 1956	
PHYSICIAN'S NAME (Type) WOMC Lane MD	Frostburg, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-11-1956	22c. NAME OF CEMETERY OR CREMATORIUM F' bg. Memorial Park	22d. LOCATION (City, town, or county) Frostburg, Md.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,	ADDRESS Frostburg, Md.	24a. REC'D BY REGISTRAR 7-11-56	24b. REGISTRAR'S SIGNATURE Mrs Nancy N. Rae		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1, 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

87 BROWNSTEIN'S GUIDE TO THEATRICAL STAGE DRILLS

BUREAU Y.

JUL 16 1956

REGEL V EO

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06769

Reg. Dist. No.

6767

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

D.O.A. at Memorial Hospital

3. NAME OF
DECEASED
(Type or print)First
MarthaMiddle
JaneLast
Rollins4. DATE
OF
DEATHMonth
JulyDay
23Year
19 56

5. SEX

6. COLOR OR RACE

female white

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

March 5-1879

9. AGE (In years
last birthday)

77

yrs.

10. IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Green Spring, W. Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert P. Crowfis

14. MOTHER'S MAIDEN NAME

Mary C. Seeders

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

none

17. INFORMANT

(son) William Rollin, Ridgely, W. Va.

Address

no

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause lost.

(b)

DUE TO

(c)

Coronary occlusion

Arteriosclerosis

several
years.INTERVAL BETWEEN
ONSET AND DEATH

sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING

CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour o. m.

p. m.

19

20d. INJURY OCCURRED

While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry

and find that

death resulted from: Natural causes Accident Suicide Homicide Undetermined cause

ACTUAL SIGNATURE

H. V. Deming M.D.

DATE SIGNED

July 23-1956

EXAMINER'S NAME (Type)

H. V. Deming M.D.

M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

July 23-1956

(State)

Cumberland, Maryland

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

July 26, 1956

22c. NAME OF CEMETERY OR CREMATORIUM

Greenmount Cemetery

22d. LOCATION (City, town, or county)

(State)

Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Louis Stein, Inc., Cumberland, Maryland

24a. REC'D BY REGISTRAR

DATE

July 24, 1956

24b. REGISTRAR'S SIGNATURE

W. L. Gantz M.D.

stem

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

BUREAU Y-12

JUL 25 1956

REGISTRATION

Within corporate limits

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pgce 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar for burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06770

Reg. Dist. No. 4

1. PLACE OF DEATH
o. COUNTY

6768

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

76 years

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

9 W. Second St.

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

female

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

Feb. 15-1880

9. AGE (in years
last birthday)

76
yrs.

10. IF UNDER 1YEAR

Months

11. IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY

Self employed

11. BIRTHPLACE (State or foreign country)

Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John H. Roth

14. MOTHER'S MAIDEN NAME

Susan Miller

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Sidney D. Phillips, Cumberland, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH

sudden

420.1

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause lost.

(b)

Coronary sclerosis

?

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m.
p. m.

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

H. V. Deming M.D.

DATE SIGNED

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

July 20-1956

22a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial

22b. DATE THEREOF
7-22-56

22c. NAME OF CEMETERY OR CREMATORIUM
Rose Hill Cem.

22d. LOCATION (City, town, or county)
Cumberland, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

James F. Scarpelli Cumberland, Md.

24a. REC'D BY REGISTRAR

July 22, 1956

24b. REGISTRAR'S SIGNATURE

R.W. Frantz M.D.

DEPARTMENT OF DEFENSE - BUREAU OF INVESTIGATION
MOTOR EXAMINER'S CERTIFICATE OF DATA

BUREAU V. S.

JUL 24 1956

RECEIVED

Within corporate limits

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06771

Reg. Dist. No. 4

DR. W.F.WMS. 6769

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 10 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HENRY		4. DATE OF DEATH Last SCHAUB JULY 30, 1953	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JULY 30, 1903
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 9	11. IF UNDER 24 HRS. Hours 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Kelly Springfield Tire Company		11. BIRTHPLACE (State or foreign country) FROSTBURG, MD.	
13. FATHER'S NAME LOUIS SCHAUB		14. MOTHER'S MAIDEN NAME FANNIE DUNN, Eupheam	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-07-9086	
17. INFORMANT MEMORIAL HOSPITAL		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio sclerotic vascular disease</i> Cardio 8 mos. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____ DUE TO (c) _____	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Polyuria kidneys.</i>		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-15-1955 to 7-9-1956 , that I last saw the deceased alive on 7-9-1956 , and that death occurred at 10:15 A.M. Atm the causes and on the date stated above. ACTUAL SIGNATURE <i>Wm. F. Williams</i> ADDRESS (Street, city or town, state) Cumberland, Md DATE SIGNED 7-9-56			
PHYSICIAN'S NAME (Type) Wm. F. Williams M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF July 12, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Frostburg Memorial Park	
22d. LOCATION (City, town, or county) Frostburg, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. L. Deest</i>		24a. REC'D BY REGISTRAR DATE July 11, 1956	
		24b. REGISTRAR'S SIGNATURE Winter L. Frantz, M.D.	

DEPARTMENT OF HEALTH-STATE-DEPARTMENT OF DEATH

CERTIFICATE OF DEATH

BUREAU Y.
RECEIVED
JUL 13 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06772

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Little Orleans

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

15 Mile Creek, Mudlick Hollow

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Md.

b. COUNTY

Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural-Little Orleans

d. STREET ADDRESS

R.F.D. Flintstone, Md.

e. IS RESIDENCE ON A FARM?

YES NO 3. NAME OF
DECEASED
(Type or print)

First Richard Middle Clyde

Shaver Last Schaver

4. DATE
OF
DEATH

Month July Day 1 Year 1956

5. SEX

Male

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

June 7-1940

9. AGE (In years
last birthday)

16 yrs.

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Student

10b. KIND OF BUSINESS OR INDUSTRY

School

11. BIRTHPLACE (State or foreign country)

Diana, W.Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Douglas Shaver

14. MOTHER'S MAIDEN NAME

Genevieve Collins

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Star Robins
Wade Wallizer, R.F.D. Flintstone, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Asphyxia due to drowning

INTERVAL BETWEEN
ONSET AND DEATH
sudden

929.8

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause lost.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Bathing, stepped in a deep hole, drown, unable to swim.

20c. TIME OF INJURY Month, Day, Year
Hour— a.m.— 7-1 1956
7.30 p.m.20d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office building)
15 Mile Creek20f. TOWNSHIP, NEAR (County) (State)
Little Orleans Allegany Md.21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .ACTUAL
SIGNATURE

H.V. Deming M.D.

DATE SIGNED

EXAMINER'S
NAME (Type)

H.V. Deming M.D.

M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

July 2-1956

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

July 5, 1956

22c. NAME OF CEMETERY OR CREMATORIUM

Lafayette Memorial Park

22d. LOCATION (City, town, or county) (State)

Brier Hill, Pennsylvania.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Skirpin Funeral Service, Brownsville, Pa.

24a. REC'D BY REGISTRAR

Nina L. Bender

DATE July 5, 1956

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

BUREAU X-1

JUL 6 1956

REGELIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06773

Reg. Dist. No. 4

CERTIFICATE OF DEATH

Item 18 Film G200 7-13-56 ams

6770

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				d. STREET ADDRESS 39 OFFUTT STREET	
3. NAME OF DECEASED (Type or print)		First LULU	Middle VIRGINIA	Last SILVIUS	4. DATE OF DEATH JULY 2 1956
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH MAY 22 1893	9. AGE (In years last birthday) 63 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) THREE CHURCHES, W.VA.	
13. FATHER'S NAME ROBERT ISER		14. MOTHER'S MAIDEN NAME AMANDA ELIFRITZ		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Naomi Rankin	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0 DUE TO <i>Anemia</i>				INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Pyelonephritis</i>					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/25 , 19 56 , to 7/2 , 19 56 , that I last saw the deceased alive on 7/2 , 19 56 , and that death occurred at 9:45 A.M. , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Leo H. Ley Jr.</i> M.D.				ADDRESS (Street, city or town, state) 426 N. Centre St. Cumberland, Md.	
PHYSICIAN'S NAME (Type) LEO H. LEY				DATE SIGNED 7/3/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/4/56		22c. NAME OF CEMETERY OR CREMATORIUM Abe Cemetery	
22d. LOCATION (City, town, or county) Mineral County, West Va.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE July 3, 1956	
				24b. REGISTRAR'S SIGNATURE W.L. Frank, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BR 250M15A-1703H © THE MUSEUM OF AFRICAN ART

BUREAU V. S.

UL 6 1956

REFUGEE FED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6771

CERTIFICATE OF DEATH

06774

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.		c. LENGTH OF STAY IN lb 20 days.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS Lakey Rd.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Lena		First F	Middle 	Last Singer	4. DATE OF DEATH July 19 1956	Month July	Day 19	Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1882	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	Hours 	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper at Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME William Keyser		14. MOTHER'S MAIDEN NAME Sarah Virginia Huffman						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Patient's Chart.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 155x DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH Decades Cancer of gallbladder								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o.m. p.m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Luray	(County) Virginia	(State) VA
21. I certify that I attended the deceased from June 30, 1956 , to July 19, 1956 , that I last saw the deceased alive on July 19, 1956 , and that death occurred at Luray, Virginia , from the causes and on the date stated above.								
ACTUAL SIGNATURE B. M. Schindler	M.D.		41	ADDRESS (Street, city or town, state) Luray, Virginia				
PHYSICIAN'S NAME (Type) B. M. Schindler, M.D.	DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/21/56	22c. NAME OF CEMETERY OR CREMATORIAL Green Hill Cemetery		22d. LOCATION (City, town, or county) Luray, Virginia		(State) VA		
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR July 22, 1956 W. Treat, M.D.	24b. REGISTRAR'S SIGNATURE			

BUREAU V. S.

JUL 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6772

CERTIFICATE OF DEATH

116775

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 25 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
3. NAME OF DECEASED (Type or print) First CARL Middle F. Last SLEMMER		4. DATE OF DEATH Month JULY Day 26 Year 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 22 1906
9. AGE (In years from birthday) 49 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHEMIST		10b. KIND OF BUSINESS OR INDUSTRY RUBBER INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN SLEMMER		14. MOTHER'S MAIDEN NAME ANNA HETZEL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-07-0456	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Nephritis & Uremia</i> DUE TO 592x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
INTERVAL BETWEEN ONSET AND DEATH 26 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Carbosis of liver & Aspiritis</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/15/56, 19, to 7/26/56, 19, that I last saw the deceased alive on 7/26/56, 19, and that death occurred at 6:58 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>B.J. Williams M.D.</i>		ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 7/27/56	
PHYSICIAN'S NAME (Type) RICHARD J. WILLIAMS M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 28 1956	
22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Right</i>		24a. REC'D BY REGISTRAR DATE July 28, 1956	
ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE <i>W.L. Frank, M.D.</i>	

CERTIFICATE OF DEATH

BUREAU V. S.

גנדי 31 ינואר 1956

REGELY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06776

6773

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 35 YRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 27 ARCH STREET		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.	
3. NAME OF DECEASED (Type or print) JAMES L. SMITH		First JAMES	Middle L.
4. DATE OF DEATH 7-28-56		Last SMITH	Month July
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 11, 1888 - 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CONDUCTOR	10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	11. BIRTHPLACE (State or foreign country) LEON, W. VA.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME CLARK SMITH		14. MOTHER'S MAIDEN NAME ELLEN HARRIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 705-09-3645	
17. INFORMANT GLADUS AMITH		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure DUE TO Arteriosclerotic Cardio- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Vascula Disease INTERVAL BETWEEN ONSET AND DEATH Immediate			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Arteriosclerosis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May , 19 56 , to July 28, 1956 , that I last saw the deceased alive on July 19, 1956 , and that death occurred at 7:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 59 GREENE ST DATE SIGNED 7/28/56			
ACTUAL SIGNATURE Saville G WEISMUTH		PHYSICIAN'S NAME (Type) Saville G WEISMUTH	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-1-56	22c. NAME OF CEMETERY OR CREMATORIUM GOSHEN CEM.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scappelli, Cumberland, Md.		ADDRESS 101 E. Main St., Cumberland, Md.	24a. REC'D BY REGISTRAR July 30, 1956
			24b. REGISTRAR'S SIGNATURE R. R. Frantz, M. D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED
JUL 31 1956

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06777 4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		6774 Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		U.Va Mineral		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wiley Ford		d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.C.A. at Memorial Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Andrew	Middle Daniel	Last Snyder	4. DATE OF DEATH	Month July	Day 23	Year 1956
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20-1888		9. AGE (In years less birthday) 60 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Confectionary		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Andrew Henry Snyder			14. MOTHER'S MAIDEN NAME Catherine Glos					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-05-4187		17. INFORMANT (son) Robert E. Snyder, LaVale, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>Coronary sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE	<u>H. V. Deming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED July 23-1956		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 25, 1956	22c. NAME OF CEMETERY OR CREMATORIUM St. Peter & Paul Cemetery		22d. LOCATION (City, town, or county) Cumberland, Maryland (State)			
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland.		ADDRESS		24a. REC'D BY REGISTRAR July 24, 1956		24b. REGISTRAR'S SIGNATURE W.F. Frantz M.D.		

BUREAU Y. S.

JUL 25 1956

RECEIVED

William corporate
limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6775

CERTIFICATE OF DEATH

06778

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA		b. COUNTY BEDFORD		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 7 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BREEZEWOOD		d. STREET ADDRESS 75 X - 34		
d. NAME OF HOSPITAL OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) MARIAN		First MARIAN	Middle W.	Last SNYDER	4. DATE OF DEATH JULY 16 1956	Month JULY	Day 16	Year 1956
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH APRIL 4, 1892	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 4	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME FRANK WOY				14. MOTHER'S MAIDEN NAME MARY ZINN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Memorial Hospital		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Colitis INTERVAL BETWEEN ONSET AND DEATH 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Breast 10 years. DUE TO (c)								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		Month 19	Day	20d. INJURY OCCURRED White at work <input type="checkbox"/> Nat white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 9 July 1956	20f. (City or town) Somerset, Maryland	(County) Somerset Co.	(State) Maryland
21. I certify that I attended the deceased from 9 July 1956 to 16 July 1956 , that I last saw the deceased alive on 16 July 1956 , and that death occurred at 12:05 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE W. H. Van Ormer M.D. ADDRESS (Street, city or town, state) Cumberland, Maryland DATE SIGNED 16 July 1956								
PHYSICIAN'S NAME (Type) W. H. VAN ORMER								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 19, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Husband Cemetery		22d. LOCATION (City, town, or county) Somerset, Somerset Co., Maryland			(State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter S. Hoffman		ADDRESS 38C Main St, Somerset, July 17, 1956		24a. REC'D BY REGISTRAR L.R. Tracy, M.D.		24b. REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06779

6790

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY <u>Allegany</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>3 Months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		d. STREET ADDRESS <u>41 Maple Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>JAMES</u>	Middle <u>ADAMSON</u>	Last <u>STEWART</u>	4. DATE OF DEATH Month <u>July</u>	Day <u>20</u>	Year <u>19 56</u>	
S. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>7-11-1880</u>	9. AGE (In years lost birthday) <u>76 yrs.</u>	IF UNDER 1 YEAR Months <u>76</u>	IF UNDER 24 HRS. Days <u>0</u>	Hours <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Substation Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Potomac Edison</u>		11. BIRTHPLACE (State or foreign country) <u>Midlothian, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John M. Stewart</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Williamson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-10-471</u>		17. INFORMANT <u>Ralph Stewart, Frostburg, Md.</u>		41 Maple Street,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Caecum</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Womc Lane</u>		20f. (City or town) (County) (State) <u>Frostburg</u>	
21. I certify that I attended the deceased from <u>Feb 1, 1956</u> , to <u>July 20, 1956</u> , that I last saw the deceased alive on <u>July 19, 1956</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Womc Lane</u> M.D. ADDRESS (Street, city or town, state) <u>167 E Main</u> DATE SIGNED <u>July 21 1956</u> PHYSICIAN'S NAME (Type) <u>Womc Lane MD</u> Frostburg Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-22-56</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Frostburg Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg</u> Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Benard H. Montague</u>		ADDRESS <u>HAFER FUNERAL HOME</u>		24a. REC'D BY REGISTRAR <u>DATE 7-23-56</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. R. C. Price</u>	
VS A15 (4) 1SM 9/55		23. F. MAIN, FROSTBURG, MD.					

CERTIFICATE OF DEATH

BUREAU V. S.
REGELIVE
JUL 25 1956

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

DR. WEISMAN

6776

CERTIFICATE OF DEATH

06780

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 95 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. STREET ADDRESS 523 WASHINGTON ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First EMMA	Middle C	Last STINGLEY
4. DATE OF DEATH	Month JULY	Day 13	Year 1956
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 24, 1896
9. AGE (In years lost birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME THOMAS F. MYERS		14. MOTHER'S MAIDEN NAME EMILY SUTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No.		16. SOCIAL SECURITY NO. None.	17. INFORMANT MEMORIAL HOSPITAL - WARWICK & MEMORIAL AVES. Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO ANEMIA DUE TO ABOVE		12 mos	
{ DUE TO (b) AND HEART FAILURE Due to ANEMIA		3 mos	
{ DUE TO (c) AND HEART FAILURE Due to ANEMIA		3 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH [If either, NOTIFY MEDICAL EXAMINER]		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 9, 1956 , to July 13, 1956 , that I last saw the deceased alive on July 13, 1956 , and that death occurred at 7:40 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 596 GREENE ST	
ACTUAL SIGNATURE S. G. WEISMAN, MD		DATE SIGNED 7/13/56	
PHYSICIAN'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 7/16/56		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cem.	
22d. LOCATION (City, town, or county) Cumberland Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Jr.		24a. ADDRESS Cumb. Md	
24b. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE July 16, 1956 W. F. Tracy, M.D.	

DEPARTMENT OF STATE - BUREAU OF HUMAN - RELATIONS - CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

BUREAU X E

JUL 18 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6791

CERTIFICATE OF DEATH

06781

Reg. Dist. No. 6

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Krooken Nursing Home				d. STREET ADDRESS 215 Virginia Ave.				
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Arthur Andrew Thomas		First	Middle	Last	4. DATE OF DEATH July 28 1956	Month	Day	Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH May 29 1887	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Kansas				
12. CITIZEN OF WHAT COUNTRY? U.S.								
13. FATHER'S NAME Andrew Thomas				14. MOTHER'S MAIDEN NAME M. Alice Wymore				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT James Thomas		Address Cumberland		
no								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Diabetes mellitus</i> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes mellitus</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>July 23, 1956</i> , to <i>July 28, 1956</i> , that I last saw the deceased alive on <i>July 28, 1956</i> , and that death occurred at <i>10A M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>James H. Wolverton Jr.</i> M.D. ADDRESS (Street, city or town, state) <i>Pedmont W. Va.</i> DATE SIGNED <i>7-30-56</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 30, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Levels W. Va.		22d. LOCATION (City, town, or county) Levels (State) W. Va.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>James Scapelli Cumberland</i>				ADDRESS 24a. REC'D BY REGISTRAR DATE 1-30-56 24b. REGISTRAR'S SIGNATURE <i>Dear C Kelly</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BY BERNARD LASERMAN TO THE NEW YORK STATE LEGISLATURE
INTRODUCED BY ASSEMBLY MEMBER JAMES J. MULDOON

BUREAU V.I.A.

July 31 1956

KFEGELV EDE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06782

Reg. Dist. No.

6777

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the reg. or 2 with the reg. or 2 with the reg. or removal.

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN lb

90 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Sacred Heart Hospital

3. NAME OF
DECEASED
(Type or print)

First
William

Middle
E

Last
Thompson

4. DATE
OF
DEATH

Month
July

Day
6

Year
1956

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Aug. 8-1865

9. AGE (In years
last birthday)

90

10. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Retired - car inspector

10b. KIND OF BUSINESS OR INDUSTRY
B&O R.R.

11. BIRTHPLACE (State or foreign country)
Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Manuel Thompson

14. MOTHER'S MAIDEN NAME

Ella Frost

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Sacred Heart Hospital records.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

902.0
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

Intrathoracic hemorrhage due to a crushed

INTERVAL BETWEEN
ONSET AND DEATH
1.1/4 hrs.

DUE TO

also had a rupture of the liver & spleen.

(b)

DUE TO

a fall.

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES **NO**

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Blind, fell over bannister from second floor porch.

20c. TIME OF INJURY Month, Day, Year

4.15
Hour
p.m.
7-6

1956
Month
Year
at work Not while
at work

20d. INJURY OCCURRED

While
at work Not while
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

Home

20f. (City or town)

Cumberland

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

H.V. Deming M.D.

DATE SIGNED

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

July 7-1956

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

7/9/56

22b. DATE THEREOF

St. Patrick's Cem

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

Cumberland, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

John J. Hafer, Cumberland, Maryland

ADDRESS

24a. REC'D BY REGISTRAR

July 9, 1956

24b. REGISTRAR'S SIGNATURE

O.R. Frank, M.D.

BUREAU V. S.
REGELIVE

JUL 10 1956

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06783

6778

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Alllgany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 606 Shriver Ave		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Carrie		First Carrie	Middle MAY	Last Thrush	4. DATE OF DEATH April 22, 1956	Month 4	Day 22	Year 1956	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1871	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 0		IF UNDER 24 HRS. Days 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Dyche				14. MOTHER'S MAIDEN NAME Nancy Dawson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT XXXXXX George Thrush, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				Carcinoma of Ascending Colon with Pulmonary Metastasis					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH Unknown					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 441 N. Center St.	(County) Cumberland, Md.	(State) MD	
21. I certify that I attended the deceased from 7-17-1956 , to 7-26-1956 , that I last saw the deceased alive on 7-26-1956 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 441 N. Center St.									
ACTUAL SIGNATURE William P. James	DATE SIGNED 7-28-56								
PHYSICIAN'S NAME (Type) William P. James, M.D.	Cumberland MD								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 29, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park	22d. LOCATION (City, town, or county) Cumberland, Md.	(State) MD					
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George, Cumberland, Md.				ADDRESS	24a. REC'D BY REGISTRAR July 29, 1956	24b. REGISTRAR'S SIGNATURE H. Wayne George, O.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUL 31 1956

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06784

Item 18 Film G200 7-13-56 ams

Reg. Dist. No.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY	6779 Allegany	MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Cumberland	c. LENGTH OF STAY IN 1b 11 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Sacred Heart Hospital	

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
a. STATE Md.	b. COUNTY Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Cumberland
d. STREET ADDRESS 216 Carroll St.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First Louisa	Middle Trimble	Last	4. DATE OF DEATH July 3 1956	Month	Day	Year
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5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 23-1892	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic & cook	10b. KIND OF BUSINESS OR INDUSTRY P.J. Arendes	11. BIRTHPLACE (State or foreign country) Conn.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Charles C. Johnson	14. MOTHER'S MAIDEN NAME Phyllis Hayes
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 218-30-2309	17. INFORMANT Sacred Heart Hospital records.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia		?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 590X		
DUE TO (b) Acute nephritis		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Impacted fracture of right femur.		

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Putting trash in garbage can, fell on concrete porch.		
20c. TIME OF INJURY Hour o. m. 11 - p.m. 6-23 1956	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Back porch	20f. (City or town) Cumberland, Allegany
		(County) Md.	(State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
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ACTUAL SIGNATURE H.V. Deming M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> July 3-1956	DATE SIGNED
EXAMINER'S NAME (Type) H.V. Deming M.D.		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 6, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Burial Park	22d. LOCATION (City, town, or county) Cumberland, Maryland.	(State)
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23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland.	ADDRESS John	24a. REC'D BY REGISTRAR July 5, 1956	24b. REGISTRAR'S SIGNATURE W.L. Frank, M.D.
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BUREAU V. S.

JUL 6 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits

06785

6780

CERTIFICATE OF DEATH

Reg. Dist. No.

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 9 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 8 HARRISON STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First VERNA	Middle TROUT	Last TROUT	4. DATE OF DEATH JULY 19	Month 19	Day Year 1956
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH AUGUST 23, 1881	9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) NEEDMORE, PENNA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN SNYDER				14. MOTHER'S MAIDEN NAME JANE GORDEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Helen Hayhurst, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 602X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		DUE TO (b) <i>Hypertension</i>		<i>Hypertensive Calculus R.</i>		INTERVAL BETWEEN ONSET AND DEATH 12 days	
		DUE TO (c) <i>chronic myocarditis</i>				2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 5, 1956</i> to <i>July 19, 1956</i> that I last saw the deceased alive on <i>July 19, 1956</i> , and that death occurred at <i>4:02 P.M.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Cumberland</i>	
ACTUAL SIGNATURE <i>Clay Durrett</i>						DATE SIGNED <i>7/20/56</i>	
PHYSICIAN'S NAME (Type) DR. CLAY DURRETT							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 22, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		ADDRESS Charles L. George, Cumberland, Md.		24a. REC'D BY REGISTRAR July 22, 1956		24b. REGISTRAR'S SIGNATURE A.R. Fautz, M.D.	

CERTIFICATE OF DEATH

NAME

ADDRESS

AGE

SEX

MATERIAL

DEATH DATE

TIME

CAUSE

DEATH

TIME

BUREAU V.

JUL 04 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06786

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Moscow, Md.		b. COUNTY Allegany	
c. LENGTH OF STAY IN 1b 4 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Moscow, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Moscow, Md.		d. STREET ADDRESS Moscow, Md.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Frank Louis Wilt		4. DATE OF DEATH July Month 30 Day Year 19 56	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 29, 1887	
9. AGE (In years lost 88 to today) yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
11. BIRTHPLACE (State or foreign country) W. Va. Paper Mill		12. CITIZEN OF WHAT COUNTRY? Maryland U.S.	
13. FATHER'S NAME Frank W. Wilt		14. MOTHER'S MAIDEN NAME Not Known	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. - - - - -	
17. INFORMANT Louis Wilt		Address Winchester, Virginia	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart failure DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Essential Hypertension DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH Several yrs. " " " "	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19, 1956, to July 30, 1956, that I last saw the deceased alive on July 28, 1956, and that death occurred at 7:15 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Leslie R. Miles, Jr., M.D.		ADDRESS (Street, city or town, state) Lonaconing, Md. DATE SIGNED	
PHYSICIAN'S NAME (Type) Leslie R. Miles, Jr., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August 2, 1956	
22c. NAME OF CEMETERY OR CREMATORIAL Morrison Cem.		22d. LOCATION (City, town, or county) (State) Allegany Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE El Royal		24a. REC'D BY REGISTRAR ADDRESS	
		24b. REGISTRAR'S SIGNATURE DATE 8-5-56 George Kelly	

RECEIVED
BUREAU X-5

AUG 8 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6808

CERTIFICATE OF DEATH

06787

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage-rural		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM		4. DATE OF DEATH Month July Day 7 , Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-31-1877
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired miner		10b. KIND OF BUSINESS OR INDUSTRY coal mines	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James H. Winebrenner		14. MOTHER'S MAIDEN NAME Susanna Logsdon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT 213-01-46674 Mrs. Grahame Bowers, Mt. Savage, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 yrs. <i>Chronic Myocarditis</i>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 54 , to July 7 , 19 56 , that I last saw the deceased alive on July 6 , 19 56 , and that death occurred at 54 M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>John A. Topper</i> PHYSICIAN'S NAME (Type) <i>John A. TOPPER</i>		ADDRESS (Street, city or town, state) <i>Hagerstown, Md.</i> DATE SIGNED <i>7/8/56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-9-1956	
22c. NAME OF CEMETERY OR CREMATORIAL Porter Cemetery		22d. LOCATION (City, town, or county) Eckhart (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR Veronica McDermit		24b. REGISTRAR'S SIGNATURE Veronica McDermit	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	DEATH DATE	TIME	CAUSE OF DEATH
WILLIAM HENRY BROWN	60	M	JULY 16, 1956	10:00 A.M.	HEART DISEASE
ADDRESS OF DECEASED					
111 E. 36TH ST., NEW YORK, N.Y.					
NAME AND ADDRESS OF PHYSICIAN					
DR. JAMES H. COOPER 111 E. 36TH ST., NEW YORK, N.Y.					
NAME AND ADDRESS OF FUNERAL DIRECTOR					
J. W. COOPER 111 E. 36TH ST., NEW YORK, N.Y.					
NAME AND ADDRESS OF PERSON REPORTING					
FBI-BUREAU OF INVESTIGATION 111 E. 36TH ST., NEW YORK, N.Y.					
RECEIVED					
JUL 16 1956					
BUREAU, N.Y.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6781

CERTIFICATE OF DEATH

06788

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 9 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Cumberland rural				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS Pt. # 3 Bedford Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) William J. Winfield		First	Middle	Last	4. DATE OF DEATH 7 27 1956	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/5/85		9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Md. Cumberland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Winfield			14. MOTHER'S MAIDEN NAME Catherine Liobel					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-05-4596		17. INFORMANT Chart Mary Winfield		Address Bedford Rd.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 12 hours						
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Cerebral Arteriosclerosis								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Nephritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month —	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cumberland, Md.	(County)	(State)	
21. I certify that I attended the deceased from 7/24/56 , 19____, to 7/27/56 , 19____, that I last saw the deceased alive on 7/26/56 , 19____, and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md.								
ACTUAL SIGNATURE <i>D. Williams</i>	DATE SIGNED 7/27/56							
PHYSICIAN'S NAME (Type) Richard J. Williams								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-30-56	22c. NAME OF CEMETERY OR CREMATORIUM St. Peters & Paul Cem	22d. LOCATION (City, town, or county) Cumberland, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR July 30, 1956		24b. REGISTRAR'S SIGNATURE W. Frank, M.D.			

